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HEALTH CARE COST: DEFINING THE ISSUES, 1983

HEARINGS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

ON

EXAMINATION OF THE MYRIAD OF ISSUES INVOLVING RISING HEALTH CARE COSTS

MAY 19 AND 25, 1983

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HEALTH CARE COSTS: DEFINING THE ISSUE, 1983

THURSDAY, MAY 19, 1983

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The committee met, pursuant to notice, at 9:47 a.m., in room SD-430, Dirksen Senate Office Building, Senator Orrin Hatch (chairman) presiding.

Present: Senators Hatch, Nickles, Denton, Quayle, Kennedy, and Metzenbaum.

OPENING STATEMENT OF SENATOR HATCH

The CHAIRMAN. I am pleased today to chair the first of two days of hearings of the Senate Labor and Human Resources Committee on the myriad of issues involving rising health care costs. I thank the many witnesses who will be presenting testimony here today.

The issues to be discussed will center on the critical question: Why are we experiencing continued double-digit inflation in the health care marketplace? Our hearings will continue on May 25 when the discussion will shift to proposed solutions for restraining this inflation.

Currently, we are beginning to see recovering trends in our economy. Inflation in 1982 was held at below 4 percent. In February of this year, consumer prices fell 0.2 percent, only the second time since 1965. Furthermore, industrial production rose 0.3 percent in February for the third monthly increase in a row. In March, housing starts rose 75 percent over March 1982 levels. Unfortunately, the area where we are clearly losing ground is in medical costs, which are rising this year at an annual rate of nearly 10 percent. Further, hospital expenditures are not only the most rapidly increasing component of total health care expenditures, but are also the largest component, comprising 41.2 percent of the total national health care expenditures.

There are numerous and complex factors that affect health care costs. The most important components are: one, prices; two, population changes; three, utilization of services; and, four, intensity of services provided to patients. Although general inflation has largely contributed to the increases in health care costs over the last decade, the remaining increase is due to changes in the composition of goods and services consumed by patients. And, of course, overall inflation should be a decreasing part of health care inflation in the future.

Nonetheless, we are all feeling the pain from health care costs. The result is a significant and heightened concern for the future of the health care financing system. Strains have been placed on both the public and private financing of health care.

As we focus on health care cost problems in what is certain to be a critical way, I think it is important to state that I, for one, have not lost sight of the fact that the United States has the most advanced, the most available, and the best system of health care and medicine in the world today. Those who deliver and pay for the health care of this country have a right to be proud of their part in making the American health care system as extraordinarily good as it really is.

Furthermore, I would be remiss if I did not recognize the efforts of many health care providers in trying to reduce health care costs. For instance, dentistry's records of cost restrain is, in my opinion, an impressive one. By emphasizing less expensive preventive care and requiring patient financial participation in prepaid dental plans, the cost of dental services has risen at a rate far below other segments of the health care sector. In addressing this important issue, I would urge my colleagues to read the statement submitted for this hearing by the American Dental Association.

Finally, to reiterate, I have called these hearings to define the issues involved in rising health care costs. Specifically, I have called these hearings to learn from the experts why health care costs have continued to rise and what aspects of health care costs should receive our greatest attention.

I am hopeful that today's witnesses will help me and my colleagues to better understand these issues surrounding the ever-increasing cost of health care.

I would particularly like to welcome Secretary Heckler and thank her for joining our hearing today.

However, prior to calling on Senator Metzenbaum, let me at this time submit for the record a paper entitled "Health Care Costs: A Discussion Paper." This paper details important background material on all aspects of the health care system and its relationship to prices.

I would like to extend my appreciation to Janet Lundy, Congressional Research Service, Library of Congress, for her help in assisting with the development of this paper. We are very happy to have it.

[The paper referred to above follows:]

HEALTH CARE COSTS: A DISCUSSION PAPER

BY SENATOR ORRIN G. HATCH

CHAIRMAN, SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

Health Care Costs: A Discussion Paper

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2. Growth in Health Care Costs
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   - B. Sources of Health Care Spending
   - C. Federal Health Care Spending

3. Reasons for the Growth in Health Care Spending

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   - A. Regulation of the Health Care Industry
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I would like to extend my appreciation to Janet Lundy, Congressional Research Service, for her help in developing this document.

HEALTH CARE COSTS AND COST CONTAINMENT

1. The Problem

For decades, health care spending in the United States has risen in aggregate terms and as a percent of the Gross National Product (GNP). By 1981, total national health expenditures had reached $286.6 billion. Health's share of the GNP increased from 6.0 percent in 1965 to its highest level, 9.8 percent in 1981. Projections by the Department of Health and Human Services are that such spending could increase to $756 billion by 1990, or 12.0 percent of the GNP.

One of the concerns about health care spending is that its growth has generally outpaced growth in the general economy. In 1982, for example, health care spending increased by approximately 12 percent, while the overall economy grew by approximately 6 percent.

Spending for health care is also a major and growing part of the Federal budget, now amounting to more than 10 percent (excluding spending for health by the Defense Department and the Veterans Administration). More than 90 percent of the Federal health budget is spent on the Medicare program (for the aged and cetain disabled) and the Medicaid program (for the poor).

Numerous proposals and attempts have been made over the past decade to reduce rising health care costs, especially hospital costs which are the major component of the Nation's health care spending. In recent years, most of the attention in Congress and the Executive Branch has focused on ways of bringing Federal spending for health care under some degree of control. However, health spending has proved difficult to control, and past attempts have not proved successful in the long run.

2. Growth in Health Care Cost

A. National Health Expenditures

National health expenditures comprise all spending in this country for health services and supplies, non-profit research, and construction of medical facilities. National health expenditures totaled $286.6 billion in 1981 and were nearly 10 percent of GNP.

Table 1

AGGREGATE AND PER CAPITA NATONAL HEALTH EXPENDITURES, AS A PERCENTAGE OF GROSS NATIONAL PRODUCT (GNP), SELECTED YEARS

Calendar Year	Total Amount (in billion)	Annual Increase	Per Capita	Percent GNP
1960	$26.9	---	$146	5.3%
1965	41.7	---	211	6.0
1970	74.7	---	358	7.5
1975	132.7	---	604	8.6
1976	149.7	12.8%	674	8.7
1977	169.2	13.1	755	8.8
1978	189.3	11.9	836	8.8
1979	215.0	13.6	938	8.9
1980	249.0	15.8	1,075	9.5
1981	286.6	15.1	1,225	9.8

Source, Department of Health and Human Services

Spending for personal health care services (including hospital care, physician services, nursing home care, etc., accounts for about 90 percent of all National health expenditures. Spending for hospital care is the largest share of all outlays for personal care services, representing nearly 50 percent of the total. Physicians' services account for a little more than 20 percent of personal care expenditures. Spending for nursing home care, now nearly 10 percent of the total, is the fastest growing component of spending for personal care.

Table 2

Personal Health Care Expenditures, By Type, Selected Years
(amounts in billions)

	1950		1960		1970		1981	
Expenditures	Amount	%	Amount	%	Amount	%	Amount	%
Hospital care	$3.9	35.8	$9.1	38.4	$27.8	42.7	$118.0	46.3
Physicans Serv.	2.7	24.8	5.7	24.1	14.3	22.0	54.8	21.5
Nursing home care	.2	1.8	.5	2.1	4.7	7.2	24.2	9.5
Other services	4.1	37.6	8.4	35.4	18.3	28.1	58.0	22.7
Total........	$10.9	100.0	$23.7	100.0	$65.1	100.0	$255.0	100.0

Source: Department of Health and Human Services

Increases in the price of health care, as measured by the Consumer Price Index (CPI), have generally exceeded price increases in the rest of the economy.

Table 3

Percent Increase from Previous Year in Selected Components of The C.P.I., Selected Years

Year	CPI all items	items less medical care	CPI, all care Total	Medical Hospital Room	Physicians Services
1965	1.7	1.5	2.5	5.6	3.6
1970	5.9	5.8	6.3	12.9	7.5
1971	4.3	4.1	6.5	12.2	6.9
1972	3.3	3.3	3.2	6.6	3.1
1973	6.2	6.4	3.9	4.7	3.3
1974	11.0	11.1	9.3	10.7	9.2
1975	9.1	8.9	12.0	17.2	12.3
1976	5.8	5.5	9.5	13.8	11.3
1977	6.5	6.2	9.6	11.5	9.3
1978	7.7	7.6	8.4	11.0	8.3
1979	11.3	11.4	9.3	11.4	9.2
1980	13.5	13.6	10.9	13.1	10.6
1981	10.4	10.3	10.8	14.8	11.0
1982	6.1	5.9	11.6	15.7	9.4

(1) CPI index for all urban consumers, unadjusted figures

Source: Department of Labor

B. Sources of Heath Care Spending

Unlike other goods and services for which the consumers pays the provider directly, health care payments are often made by other entities which act as insurers. Table 4 shows the major sources of national health expenditures including *public sources*, such as the Medicare and Medicaid programs, and *private sources*, such as direct patient spending and payment by private health insurance. Since 1965, the portion of spending by public sources has increased (from 26 percent in 1965 to 43 percent in 1981). Most of the increase in public spending represents spending by Federal programs (from 13 percent in 1965 to 29 percent in 1981 . Accordingly, the portion of spending by private sources in total has decreased (from 74 percent in 1965 to 57 percent in 1981). While this share of spending by patients from their own pockets has decreased (from 44 percent in 1965 to 29 percent in 1981, the share of spending by private insurance has increased slightly (from 24 percent in 1965 to 26 percent in 1981).

Table 4

Sources of National Health Spending, 1965 and 1981

SOURCE	1965	1981
Public	26%	43%
Federal	(13%)	(29%)
State and Local	(13%)	(14%)
Private	74%	57%
Patients	(44%)	(29%)
Insurance	(24%)	(26%)
Other	(6%)	(3%)
Total	100%	100%

*Percentages may not add due to rounding

Source: Department of Health and Human Services

C. Federal Health Care Spending

Spending for health is now a major and growing component of the Federal budget. Outlays for the health functin of the Federal budget (which excludes spending for health by the Department of Defense and the Veterans Administration) have risen from $1.7 billion in FY 1965 (or 1.4 percent of the total Federal budget) to $74.0 billion in FY 1982 (or 10.2 percent of the Federal budget. Approximately 90 percent of the Federal health function outlays is consumed by the Medicare and Medicaid programs.

Table 5

Federal Health Outlays, Amount

tAnd Percent of Total Federal Outlays, Selected Years

Fiscal Year	Federal Health outlays* (in billions)	% of Total Federal Budget
1965	$1.7	1.4%
1975	$25.7	7.9%
1982	$74.0	10.2%

*health function component of the Federal health budget

Source: Budget of the U.S. Government, various years.

3. Reasons for the Growth in Health Care Spending

According to the Department of Health and Human Services, National health expenditures increased at an average annual rate of 13.2 percent between 1971 and 1981. Numerous and complex factors, economy-wide and those specific to the health sector, account for the increasing cost of health care. Economy-wide factors include: (a) general inflation in the economy as a whole, which accounted for the largest proportion, approximately 57 percent, of the increases in health care costs from 1971 to 1981; and (b) aggregate population increases including the "aging" of our population, which accounted for approximately 8 percent of the 1971-1981 health care cost increases.

Factors specific to the health sector which contribute to health care cost increases include: (a) medical care price increases in excess of economy wide price increases, which accounted for approximately 7 percent of the health care costs increases from 1971-1981; and (b) growth in health care services per capita, including increases in the number of visits to health care practitioners and the number of patient days in health facilities and increases in the mix and content of health care services and supplies per visit or per day, a factor which contributed approximately 28 percent to the increase in health care costs from 1971-1981.

Table 6

Factors Accounting for Growth in Personal Health Care Expenditures, 1971 to 1981

Average Annual Rate of Growth	13.2%

Factors Underlying Rate of Growth	Portion of Growth Rate
Economy-wide Factors	
a. General inflation	5.86%
b. Aggregate population growth	7.9%
Factors Specific to the Health Sector	
c. Medical care price increases relative to general inflation	7.0
d. Growth in health care services per capita	28.3
TOTAL	100.0%

Source: Department of Health and Human Services

A number of features peculiar to the health sector help explain the increases specific to this sector of the economy. First, third-party payers (i.e., organizations that pay for health expenses, such as private insurers, Blue Cross/Blue Shield, Medicare, or Medicaid) finance the overwhelming proportion (approximately 70 percent) of health care in this country. As a result, the actual out-of-pocket cost of health care for most patients is small, insulating them from the real costs of the health care provided to them. In addition, insurance leaves the providers of health care (e.g., physicians, hospitals, etc.) with little incentive to be cost-conscious in the type of quantities of services provided to their patients, since there is little direct financial burden on the patients., This process may even be self-reinforcing: the high cost of health care creates pressures for even more comprehensive third-party coverage, and the expanded coverage, in turn, enables hospitals and physicians to provide even more costly care. The growth of private health insurance has also been stimulated by the tax treatment of health benefits, expecially the exclusion of employer contributions from taxable employee income.

A second feature which contributes to health care cost increases includes the reimbursement systems used by most third-party payers to pay for health care services. Certain of these systems, including retrospective cost-based reimbursement for hospitals and fee-for-service reimbursement for physicians, provide incentives which increase health care costs. Retrospective cost-based reimbursement means that the hospital is paid for the costs it incurrs in providing a service after the care has been provided (i.e., retrospectively). Many critics of this method argue that this reimbursement method encourages hospitals to spend more, since the more a hospital spends to provide a service, the larger its reimbursement will be. Some observers have questioned whether hospital costs can be adequately contained without establishing in advance the amount or rate of payment the hospital will receive (i.e., prospective reimbursement) rather than paying the costs of care after the services have been provided. In similar fashion, reimbursing physicians on a fee-for-service basis, where physicians are reimbursed their charges after the care is provided, contains few incentives for them to be cost-conscious in their provision of care.

4. Efforts to Contain Health Care Costs

Over the last decade, numerous proposals and attempts have been made to control inflation and excessive growth in the health care industry. Efforts to control health care costs may be grouped into 3 broad categories:

--Regulaton, which is defined as the intervention of government in the health care market to control entry into that market or to change the behavior of participants in that market,

--Market-oriented strategies for changing the existing health care to introduce certain incentives to make the existing system more like a competitive economic market, and

--Voluntary private initiatives, developed by participants in the health care industry itself or by employers who pay for health insurance for their employees.

A. Regulation of the Health Care Industry

One broad category of health care cost containment efforts includes examples of the regulatory approach to controlling health care costs. It is this type of approach which has been used most frequently in the past decade to control health care costs, often without much success.

Direct economic controls were placed on the health care industry from 1971 to April 1974, when the Federal Government imposed economy-wide wage and price controls under the Economic Stabilization Program. Under these controls, not only were the rates of increase in medical care prices reduced, but these rates, for the first time, dropped below the rates of increase in prices for the economy as a whole. However, when the controls were lifted, the rates of increase for medical care rose significantly and once again exceeded price increases for the whole economy.

Another regulatory approach to controlling health care costs occurred during the 1970's when Congress established a number of programs designed to deal with some of the perceived causes of sharply increased spending for health care. These programs included the health planning and certificate of need program, which requres States and localities to evaluate and approve proposals to construct new health facilities or to provide new equipment or services, in order to improve access to health care, to prevent the duplication of costly health resources, and to contain costs. Another example was the Professional Standards Review Organization program, which was designed to review the appropriateness of care provided to Medicare and Medicaid beneficiaries in health care institutions. Attempts have been made in recent years to modify or repeal these programs for a number of reasons, including what is believed by some to be their burdensome regulatory aspects and their uncertain impact in reducing health care costs. However, there are others who believe that such regulatory programs are necessary to control health care spending, at least until some system-wide changes are made in the present health care system.

Borrowing in part from the experience of the wage and price control period, in an attempt to regulate hospital costs, the Carter Administration asked both the 95th and 96th Congresses for authority to impose mandatory Federal limits on the annual rates of increase in hospital revenues for inpatient services provided to both public and private patients. Congress was also asked to approve an annual National limit on new spending for construction of health facilities and for equipment. After several years of heated debate, Congress rejected both of these proposals. Some of the reasons for the opposition were that the proposals:

--would unfairly single out the hospital industry for price controls,

--they would harm health care by forcing hospitals to curtail services in order to keep costs down, and

--they were unnecessary because the health care industry could voluntarily bring down the rate of hospital cost inflation.

In addition, in an effort to make the impact of the proposals on hospitals with varying characteristics more equitable, the proposals were amended to include so many exceptions that most of the cost savings were lost.

Another regulatory approach includes certain reimbursement limits established under the Medicare program in order to control Federal spending for this program. Limits on the rate of Medicare reimbursement to hospitals have been established annually since 1974. These limits are commonly known as "Section 223" limits since authorizing legislation for them was contained in Section 223 of the Social Security Amendments of 1972. Prior to the Tax Equity and Fiscal Responsibility Act of 1982, the Section 223 limits covered only inpatient routine operating costs, which represented approximately 40 percent of the total hospital costs which Medicare reimbursed. The 1982 Tax Act extended the limits to cover all inpatient operating cots and provided for an adjustment for the case mix (i.e., the types of patients treated) of the hospital. In addition, the 1982 Tax Act authorized a new limit on Medicare reimbursement to hospitals, a 3-year ceiling on the allowable rate of increase in the costs of hospital inpatient services, with incentive payments to hospitals that keep their costs below their target ceilings. The Medicare program also establishes limits on reimbursement to physicians.

Although these various regulatory limits on Medicare reimbursements to health care providers do restrain the amount of Federal spending for this program, the cost savings have not, up to this point, been significant in terms of overall program spending. Critics of Medicare reimbursement methods have said that the establishment of limits is not enough--that changes in the methods of reimbursement need to be made to give health care providers incentives to be more cost-conscious. Other critics argue that regulating the costs of only the Federal programs will not significantly affect the costs of the total health care system.

Changing existing methods for reimbursing hospitals is another example of the regulatory approach to controlling health care costs. One example of this approach is rate regulation, where an external authority (such as the Federal or a State Government, or a rate-setting commission) establishes a payment rate for reimbursing the hospitals under its authority. Most hospital rate regulation programs, such as those established by the States of New York, New Jersey, Maryland, and others, use a method of reimbursement known as prospective payment, under which the rate-setting authority establishes the payment rate in advance, before the services are provided. Many have argued that only if a hospital payment rate is fixed in advance of the provision of services is there any incentive for a hospital to be more efficient or cost-conscious.

In addition to the States which have prospective payment programs for hospitals, the Administration recently proposed and Congress enacted legislation for the prospective payment of hospitals by the Medicare program (Title VI of P.L. 98-21, The Social Security Amendments of 1983). Beginning October 1, 1983, Medicare will reimburse hospitals according to prospectively-determined payment rates. These payment rates will be the average cost, nationwide, for treating a Medicare patient according to his or her diagnosis. The classification system used to group hospital patients according to their diagnosis is known as Diagnosis Related Groups, or DRGs. For example, subject to certain adjustments, all hospitals will be paid the same amount for treating a Medicare beneficiary diagnosed as having appendicitis.

The system will be phased in over three years, during which time the payment rates will be based on a mixture of (1) the former cost-based reimbursement amounts and (2) the prospective DRG rates. Certain hospitals (childrens', psychiatric and long term care) and certain costs (direct medical education and capital) will be exempted from the prospective payment system and will continue to be paid on the basis of reasonable cost (capital costs, however, would cease to be paid according to reasonable cost starting October 1, 1986). Certain adjustments to the payment rates are provided for cases involving unusually long lengths of stay or unusually high expenses. Authority is provided for States to establish their own Medicare hospital payment systems which meet certain Federal requirements.

Recent studies of State hospital rate regulation programs using prospective payment methods indicate that such programs have generally been effective in bringing down the rate of increase in spending for hospital care. However, many of these programs are relatively new, some have been evolving and changing over time, and problems with State programs do exist. Critics question whether the payment methods are sophisticated enough to measure the real costs hospitals incur in providing care. Others question whether there is an incentive for hospitals to skimp on care in order to maximize their profits. There have been problems with the administration of such programs, such as setting of the prospective rates and reviewing requests for exceptions in a timely fashion.

In regard to the proposal to reimburse hospitals by Medicare on a prospective basis, critics question whether this method has been sufficiently demonstrated in the States to determine whether suitable for application to nationwide Medicare hospital reimbursement system. Another problem is that any reductions in Federal reimbursement to hospitals may only result in hospitals increasing their charges to non-Federal payers for hospital services. Thus, costs would merely be shifted from the Federal Government to other payers, and costs would not be reduced for the health care system as a whole.

B. Market-Oriented Strategies

Certain market-oriented stategies have been proposed as alternatives to a regulatory approach to containing health care costs. The market-oriented strategies are designed to create incentives which make the existing health care financing and delivery system operate more like a properly functioning economic market. In such a market, the sellers of goods or services (in other words, doctors, or hospitals) are responsive to the choices that price-sensitive consumers (or patients) express through their willingness to pay for goods and services. In addition, in a properly functioning market, sellers use resources efficiently in producing these goods and services, due to the competitive pressures of many other sellers, ensuring that the prices of goods and services will be as low as possible.

In contrast to this description of an ideal economic market, our present market for health care services is characterized by consumers who make few choices about the types and quantities of services provided to them. The providers of health care services make those determinations and establish the prices for such services. There is little price sensitivity on anyone's part since most medical bills are paid for by insurance. Thus, there is little competition in the system to help keep prices as low as possible.

There are a number of market strategies which have been developed to restructure our present system so that it is more like a properly functioning market, including the proposals incorporating what is known as the "competition approach" to health care financing and delivery. These proposals have as their goal the promotion of increased competition among the providers of health care services, and wider consumer choice and greater price sensitivity in the selection of health benefits protection. Advocates of these proposals have recommended major changes in the design and financing of private, employment-based health benefit programs and in the tax treatment of such benefits. Some have also suggested that the competitive principles should be extended to the design of public programs, such as Medicare, as well. The competitive initiatives usually contain proposals for:

Alternative delivery systems, including encouragement of the development of health maintenance organizations (HMOs) and other entities which attempt to control health spending by placing the suppliers of services at financial risk for the provision of unnecessary care. Others suggest the development of "preferred provider organizations" (PPOs), which involve agreements between suppliers and purchasers of services at negotiated or discounted rates. Patients who choose to receive care from suppliers not on prefered lists pay higher out-of-pocket costs or receive fewer benefits, or both.

Voucher plans, including their use in Medicare, to establish fixed dollar contributions from employers and/or the Government to purchase health benefit protection from the private marketplace. Advocates argue that, if effective, voucher plans could help to reduce the demand for services, encourage consumers to shop carefully for health benefit coverage, and eventually create competitive pressures on insurers and suppliers to moderate both the prices for and the volume of services provided.

Tax law changes, including "caps" or limits on the maximum amount of employer contributions for health benefits, any amounts above which would be taxable as personal income to workers. Such changes would reduce the tax subsidies for the purchase of more health insurance and help to moderate the demand for services. Employees, the advocates say, would probably absorb more of their own health care costs directly or seek out the most competitively priced coverage available from the marketplace.

Except for certain limited amounts of Federal financial support for the development of HMOs, Congress has not adopted any of the major "competitive" alternatives to regulation. Most opponents of such proposals believe that the competitive theory will not work because the incentives will not be great enough to have an impact on provider prices or behavior. Some fear that a competitive market for health care services will lead to reductions in the availability and quality of care and in the development of new and innovative technology. Others believe that it could take many years to begin to see any results from the changes recommended by the competition advocates, resulting in insufficient cost savings in the near term.

C. Voluntary Private Initiatives

A third broad grouping of health cost containment efforts includes those initiated voluntarily in recent years by the private sector. One example of a private voluntary initiative is known as the Voluntary Effort. The Voluntary Effort was established in late 1977 at the time the Carter Administration's hospital cost containment proposal was being debated in Congress. There were many at the time who believed that if the health care industry more effectively controlled health care costs itself, there would be no need for the Federal Government to pass legislation regulating it. The private health sector responded to this challenge by establishing the Voluntary Effort. Participants in the Voluntary Effort included organizations representing health care providers, insurers, consumers, and business groups.

For each year since 1977, the Voluntary Effort formulated goals and objectives for reducing the rate of growth in health care spending. In the early years of the program, many of the goals were expressed in terms of numerical reductions in the rates of increase in various measures of health care spending. Except for 1978, these goals were generally not achieved. In recent years, the Voluntary Effort goals were more general, such as the 1982 goals which included, for example, the development of programs to improve hospital productivity and better management of health care technology. By agreement of its member organizations, the Voluntary Effort ceased to exist at the end of 1982.

Other private sector initiatives have included efforts on the part of employers and the companies from which they purchase health insurance to reduce health care spending by:

--redesigning the benefits offered in their health plans, to include increase in employee cost-sharing amounts, such as deductibles and coinsurance;

--by establishing health promotion plans, which stress exercise and better health and nutrition habits;

--by increasing utilization review activities, where appropriateness of care is examined; and

--by implementing second opinion programs for elective surgery.

In addition, a number of employers are attempting to reduce their spending for health care premiums by self-insuring, which means that the employer sets aside a certain amount of money to pay for the health care services used by his employees, rather than paying an insurance company to do so.

A last and fairly recent private sector initiative to control health care costs has been the development of what are called "health care coalitions." These coalitions are usually business-sponsored groups composed of employers who have formed to discuss and address the problems of rising health care costs in their geographic locality. Many coalitions also include local health care providers and representatives from health insurance companies. The various activities that the now approximately 100 coalitions engage in include, for example, data collection, health planning and resource allocation, the negotiation of charges and discounts with local health care providers, etc.

It is difficult to measure the impact that various private sector initiatives have had on health care cost increases. This is in part because many of these activities are relatively recent and have not had time to really get underway, let alone be thoroughly evaluated. In addition, except for the Voluntary Effort, many of these activities tend to be confined to certain cities or geographic areas, making their impact relatively small and the potential for their duplication unlikely in other areas with dissimilar characteristics.

The **Chairman**. At this time we will turn to Senator Metzenbaum.

Opening Statement of Senator Metzenbaum

Senator **Metzenbaum**. Mr. Chairman, let me say that this is a hearing that in my opinion never should be but has to be. It is a hearing that never should be because the Congress should not have the responsibility for figuring out a way to control rising health care costs. It is my opinion that Congress will act because the industry will fail to act, but the situation ought to be different. Unfortunately, we often have problems in this country where there is no other solution but for the Government to involve itself in the matter.

Yet, here we have a situation where the industry knows that rising health care costs are a problem, a challenge, and knows that Government will act if it, fails to act, and yet does very little about it.

Now I anticipate we will hear a great deal of testimony about competition, about how competition is the answer to controlling rising health care costs. It is with a certain amount of healthy skepticism that I listen to that kind of approach because, realistically speaking, there is not and cannot be that much positive competition in the health care industry.

Let me describe to you a situation, for example, in Dayton, Ohio, and I do not believe that this community is atypical of what is occurring nationwide. Health care is a growth industry in Dayton. The economy isn't such a growth industry, but health care is a growth industry. Hospitals are no longer run by professional doctors in white coats, but they are run as a business by highly paid executives. That is well and good. I have no problem about that.

However, there are five general care hospitals in the Dayton area. It is estimated that, due to fierce and bitter competition among the hospitals for paying patients, there will soon only be four. In order not to be the one that fails, each of the five hospitals has announced ambitious expansion or new construction projects.

Now it is a reality of life that every hospital in the country today thinks that they need every piece of equipment that is possibly available and that they feel if they do not have their own CAT scanner and if they do not have their own newly advanced equipment of one kind or another, that they will not have the reputation and they will not get the business.

Now the Ohio Department of Health recently reported that the Dayton area already has 219 more hospital beds than needed, but the cost of Dayton's planned hospital expansion will be in excess of one billion dollars in long-term debt. As is always true, it is the consumer who is going to pay it in the end.

Expensive and unnecessary duplication of services is not the only result of competition. Hospitals in Dayton are also spending large sums of money on public relations and advertising to attract paying patients. One hospital went from a two-person public relations staff 5 years ago to a communications staff of 11 and a marketing staff of 4 that places ads in magazines like Time and Sports

Illustrated. Now that isn't what medical care is all about, as this Senator sees it.

I would like to point out that another Dayton hospital has an eight-person public relations department and an in-house television station with better than a half million dollars annual budget and a staff of 18. That money doesn't come from nowhere; it comes from either the Government or it comes from the patients who are using that hospital. Sometimes it is a combination of the two.

However, these marketing techniques are not limited to Ohio. In Philadelphia a hospital hired a helicopter to fly over a football stadium during a game with a banner advertising its doctors.

What is happening to health care today? It is moving from the world of philanthropy to the world of big business. As a matter of fact, when you talk about big business, there is one business in this country that is growing faster than the computer business, and that is franchised medicine. The number of chain-operated, for-profit hospitals has gone from a handful in 1965 to more than a thousand. It is a good buy on the marketplace to buy stock in these franchise hospital operations. These hospital chains are very popular in the stock market because of their 25-percent annual growth rate. The for-profit hospitals had revenues totaling $8 billion last year alone.

There is real evidence that the profit motive costs patients money. The State of Florida has found that for-profit hospitals charge 14.3 percent more than nonprofit ones. That is about one out of every $7 over and above the cost of the nonprofits.

CBO found medicare was paying $3,360 per bed to nonprofit hospitals for capital costs but $7,170 to the for-profits—more than twice as much because of return on equity payments to the for-profit hospitals. Yet, the for-profit hospitals, understandably, lobbied hard against Congress eliminating the return-on-equity provisions.

Now I have with me today two bill recently given to me by people down in Florida, hospital bills which are shocking examples of health care inflation. I was on the tennis court and a woman came up to me and said: "Senator, I'd like to show you my hospital bill." Frankly, I really was not particularly interested in seeing it at that point, but she handed me this thick document of papers and I think there were 72 pages to it. It was a bill for $78,575 for a 69-day stay in a for-profit hospital. That bill does not include the doctors' charges; it is just the hospital bill alone.

Charges included $5.70 each time she was given two Tylenol—that is crazy; $11.50 for a length of Dermicel tape, and the total tape charge was $300. Sponges were $217. Swabs were $100. You can buy a hell of a lot of swabs for $100. Disposal pads were $700.

I have another bill—incidentally, also given to me on the tennis court—for $26,307 from a man who spent 20 days in the hospital. The hospital charged $7 for a 4-inch ace bandage, $31 for a 4x4 box of sponges, $18 for a 3x4 telfa pad, $25 for a pair of examination gloves.

Soon after these bills were presented to me, CBS Evening News had an exposé on the very same problem. A medicare patient with heart disease was rushed to the hospital. She lived less than 48 hours, but they were the 2 most expensive days of her life. The final hospital bill was $17,319.35. Worse yet, her $4,100 lab charge would have cost $2,300 at a nearby nonprofit hospital. The $1,900 drug bill would have been only $615. In fact, the total $17,000 bill would have been only slightly more than half at the nonprofit hospital.

I believe in the free enterprise system, but the free enterprise system isn't very free to the American taxpayer and especially not to the patients who use those hospitals.

It is not just the hospitals. A Dayton woman, 72 years old, lives on $310 a month on social security. She had knee surgery and subsequently received a bill for $2,400 from her orthopedic surgeon, who did not accept medicare assignment. Medicare valued the operation at $800, one-third of the charge, and paid the woman $565 after the copayment was deducted. She still owes the doctor $1,835 and now takes money every month from her $310 to pay an inflated fee to a surgeon who most likely earns in excess of $100,000 a year.

Now why do I mention these facts? I mention them because they prove the fact that there is a problem. If there is a problem, then we have to do something. We need a systemwide, all-payer, comprehensive program of health care cost containment, which I believe would come better from the industry itself but, unfortunately, the industry will not act. The public and private sectors—hospitals, physicians, and insurers should all be involved, but they won't.

I also believe that physicians have not accepted responsibility to the elderly and disabled in our society. As a consequence, Congress, I believe, has a responsibility to see to it that they accept medicare "assignments" that is, charge no more than the amount medicare says is reasonable. If that cannot be done by the medical societies, as an ethical imperative, then it will have to be imposed by law.

Health care for the elderly is a duty and an obligation, and it ought to be recognized as such by the industry, but it won't, and so Congress will have to act.

Many here will not like what I am saying. What I am really saying is that, if you in the health care industry do not accept your responsibility, then you give Congress no alternative and the administration no alternative but to advocate legislation that you probably will not like and that we will not write as well as you would be capable of writing, but the fact is we have no alternative and you leave us no choice.

Rising health care costs are such a problem for this Nation that if the industry fails to do anything, as I suspect they will, then Congress has a responsibility to take strong and effective action.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Kennedy.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. Thank you very much, Mr. Chairman.

I want to thank you, Mr. Chairman, for holding these hearings this morning on a subject of enormous importance to the American people and to the Congress. We who are interested in health care policy know that we are going to have to make some important decisions over the next several years because of the explosion of health care costs.

We have seen the administration's proposals to reduce health care benefits. There are many of us who believe that there are alternatives. I hope that, as a result of this hearing and other hearings that are taking place, we are going to be able to have an examination of those alternatives. These hearings have great value for the Congress and for this committee to learn about various recommendations that have been made and that we should act upon.

Health care is not a partisan issue. It affects men and women Republicans and Democrats, families with generous resources and incomes and the hard-pressed families. Hopefully, we will be guided by a commitment to equity and to fairness. When we are making decisions, we ought to evaluate any of the recommendations against the standards of fairness and equity. I think that is important, and I am sure that is the spirit in which these hearings have started.

Mr. Chairman, on your right are the projections in terms of the growth of health care expenditures. The furthest chart is based upon figures that are provided by HHS. We see from 1970 to 1990 health care expenditures rising from less than $100 billion to over $755 billion, if we do nothing at all. That is a projection of crisis proportions. We are either going to be effective in controlling costs and doing it with fairness and equity or we going to see very dramatic reductions in benefits for people who are in great need.

We see on the chart with the blue indexes the increase in the percent of GNP that we are spending in health care. You talk about increases in defense expenditures. They pale in comparison with the kinds of increases that we are talking about in health care costs.

We have had as great an increase in health care costs in percent of GNP as any other nation in the world, and yet we still find significant numbers of American people who are not receiving the most basic and fundamental care. We are spending the money, but I am troubled by the fact that we are not really getting the kind of benefits out to people who are in need.

The third chart—and I think it is rather interesting—is an indicator of what is happening in terms of the hospital cost inflator versus the Consumer Price Index. I draw this chart to the attention of the members of the committee because there have been only two times when the health care inflator has gone at the same rate as the Consumer Price Index—once, under President Nixon, when we had wage-price controls and the second, when this committee had reported out a cost containment program, and we were debating that on the floor of the U.S. Senate. That is when we were able to get the attention of health providers, from physicians and from hospitals. That is when we heard testimony in this committee that said, "Just leave us alone. Let us go through the voluntary system. Look what we have done in terms of bringing health care increases down." That was the argument of those that wanted to resist meaningful, effective cost containment programs.

If we had enacted that program at that particular time, we would have saved in excess of $50 billion today. Once that legislation was removed and disappeared, look what that chart shows.

The rate of increase of health care costs has again exploded compared with the increase in the Consumer Price Index.

Now I would hope that we will have learned something from this past experience. I do not know how many more times we are going to have to be hit over the head with these facts.

Mr. Chairman, my concern about the recommendations of the administration is that they propose to put a greater burden on the consumer than on the provider, and, that they are going to be discouraging preventive health care and primary care. I think that that does not make sense from a health point of view or from a cost point of view.

I thank the Chair for a chance to make these observations.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Senator **KENNEDY**. For over a decade, we have come together in hearing rooms like this one throughout the Capitol to lament the problem of rising health-care costs. As we sit and discuss, we have seen costs go up. More and more of each worker's dollar goes for health care. More and more of our senior's social security checks are spent to meet the skyrocketing costs that medicare doesn't pay. Our businesses stagger under the burden, our government—Federal, State, and local—faces mounting deficits despite sharp cutbacks in health services. Year after year costs go up, and year after year Congress does nothing. If we had enacted hospital-cost containment in 1978, we would have saved as much as $50 billion in hospital costs by this year—enough to send every American a check for more than $200.

Our health-care system is the best in the world—if you can afford it. My own family has been fortunate enough to receive the finest care available. But for millions of Americans, skyrocketing health costs too often mean a grim choice—to pay the doctor or pay the grocer; fill a prescription for drugs or fill a tank with heating oil; take your wife to a doctor for prenatal care or your car to the repairman so you can go out and look for a job.

The administration's incredible response to rising health-care costs is to make it even harder for Americans to pay for health care—by increasing the amounts that they must pay out of their own pockets, by taxing their health insurance, and eliminating the only weapons we have against rising health costs—health planning and PSRO's. They call this strategy making consumers cost conscious. I believe that consumers, who already pay 29 percent of their health care out of their own pocket, are well aware of the costs. The time has come for hospitals and physicians to learn to live within their budgets, just as the working family must do.

These hearings will give us an opportunity to consider what works and what doesn't in controlling health costs. I have introduced my own bill—S. 814—which would provide direct and immediate savings in hospital and physician costs by introducing prospective reimbursement throughout the health-care system. My approach would rely primarily on the States—which have already demonstrated their effectiveness in holding down health-care costs.

I hope we can move forward in the months ahead with effective proposals to control health-care costs. If we fail again, there may be no hope for saving our health system from collapse.

The CHAIRMAN. Thank you, Senator Kennedy.

Senator Nickles.

OPENING STATEMENT OF SENATOR NICKLES

Senator NICKLES. Thank you, Mr. Chairman.

I do not have any opening comments except to compliment you for having this hearing. I look forward to hearing the Secretary's comments.

We do have some challenges, needless to say, with the growing explosion in total health care costs shared both by the Government and by the private sector. It is an enormous burden on both the Government and on the private sector. It is a challenge, and it is one that I think we are going to have to work together in a bipartisan way to see if we can come up with some solutions both for the taxpayers and for the rest of us in the private sector that are still wondering how we can get by with this ever-lasting burden.

The CHAIRMAN. Thank you, Senator Nickles.

Senator Denton.

OPENING STATEMENT OF SENATOR DENTON

Senator DENTON. I will just join my colleagues in commending you, Mr. Chairman, for convening hearings on this critical topic.

I will ask that my full written remarks be included in the record.

Orally, I would just remark that the statistic that 10 percent of our Nation's gross national product is represented by health care expenditures is frightening. In addition, every member of this committee knows that the medicare program is facing severe short- and long-term financing problems. As chairman of the Subcommittee on Family and Human Services which you entrusted me with, I have gained a better understanding of how our population demographics portend even greater financial strains on the health are sector for the future.

The elderly are requiring more medical attention than any other age group, and we must prepare ourselves to care for the millions that will need medical care.

With the population growth now extrapolated to become zero in the early part of the next century, with our married couples now producing an average of 1.8 children, we are going to have to be experts at sleight of hand with our arithmetic in order to take care of social security and this particular problem. Therefore, it is one which we must contemplate and study with solemnity and thoroughness.

Thank you, Mr. Chairman.

[Prepared statement of Senator Denton follows:]

PREPARED STATEMENT OF SENATOR DENTON

Senator DENTON. Mr. Chairman, I join my colleagues in commending you for convening hearings on the subject of restraining the explosive growth in health-care costs. No subject is more de-serving of a comprehensive review than the soaring cost of providing health care to America's citizens.

Too often in the past, Congress approach to the issue has been fragmented—concentrating exclusively on public expenditures at one point and then focusing on costs incurred in the private sector at another time. These hearings, Mr. Chairman, represent a fine opportunity to get the whole picture on the financial health of the health-care industry.

Even a cursory review of the situation yields some startling facts. Health expenditures now constitute about 10 percent of our gross national product, with substantial increases in that percentage expected by 1990. The medicare system faces severe short- and long-term funding problems. As chairman for 2 years of the subcommittee concerned with aging issues, I came to understand more clearly how our population demographics presage even more severe financial strains for the health-care sector in the not-too-distant future. It is an irrefutable fact that the elderly need more medical care than any other group, and our Nation must prepare itself now to care for the millions of our elderly citizens that will require medical attention.

What can we do? The administration has proposed, and the Congress has enacted, some reforms in the medicare system. Prospective payment certainly represents a positive first step. But clearly much more must be done. I am delighted that Secretary Heckler is here today, and I am sure that she will present the administration's views on what is needed. It appears that the panels of witnesses span the ideological spectrum and represent many of the groups most directly concerned with restraining health-care costs. I particularly want to welcome Dr. Jack Meyer, who has appeared before the Subcommittee on Family and Human Services to testify on other subjects. I know his remarks will be informative. I am sure he and the others have suggestions about how the public and private sectors can coordinate efforts for maximum effect. Mr. Chairman, I look forward to being further educated on this critical national concern.

The CHAIRMAN. Thank you, Senator.

It is, indeed, a pleasure to welcome Mrs. Heckler to our hearing to discuss the status of health care in our Nation with particular regard to cost issues.

Mrs. Heckler as Secretary of the Department of Health and Human Services oversees approximately 23 percent of health care spending in this country. In view of the double-digit inflation currently experienced in the health care marketplace, I look forward, Mrs. Heckler, to your assessment of the factors attributed to these increased costs and, hopefully, some proposed solutions to address the problems.

Accompanying Mrs. Heckler is Dr. Robert Rubin, who is the Assistant Secretary for Planning and Evaluation and Mr. Thomas Donnelly, Assistant Secretary for Legislation, both from the Department of Health and Human Services.

We are grateful for both of you coming today.

It is my understanding, Mrs. Heckler, that you must leave early to be at the White House. Therefore, we will take your testimony, and then, Dr. Rubin, you are going to be able to stay and answer questions in detail.

With that, we will take your testimony at this time.

STATEMENT OF HON. MARGARET HECKLER, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DR. ROBERT RUBIN, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, AND THOMAS DONNELLY, ASSISTANT SECRETARY FOR LEGISLATION

Secretary HECKLER. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am very pleased to have this opportunity to discuss the problem of rising health care costs with you.

All of us have heard so many statistics about the rising cost of health care that the statistics have almost lost their capacity to shock us. We all know very well that the share of the Nation's GNP going to health care has grown from about 7.9 percent in 1972 to 10.5 percent in 1982. We also know that the dramatic slowing of the general rate of inflation has been accompanied, thus far, by only a comparatively small decline in the health care inflation rate: from March 1982 to March 1983, the CPI increased 3.6 percent while the CPI's medical care component increased 10.6 percent.

The result of the unabated growth in health care costs is also very familiar: Federal and State outlays on health care have been soaring, as have private insurance premiums. Over the last decade, double-digit inflation has been the norm in medicare and medicaid, with the result that those programs have been consuming an ever larger share of the HHS budget. Similarly, health benefits have consumed an ever larger share of private employee compensation.

Despite their familiarity, however, these statistics do not properly define the challenge before us. It is not inherently bad to spend money on health care. Far from it, the Nation's high level of health expenditures is testimony to the compassion of the American people and to the technological prowess of our research scientists, physicians, and other health care providers.

I am proud, as I believe you are, of the progress the Nation has made in improving access to medical care for the poor and the elderly. I am also proud of the progress we have made in treating serious diseases, such as heart disease and various circulatory problems, as well as other medical problems.

What concerns me is not simply the number of dollars being spent on health care, but the evidence that the Nation's health care system is not as efficient as it should be. Because of this inefficiency, we are missing opportunities for still larger improvements in the public health and welfare.

The challenge before us, then, is to preserve the quality of our health care system, while making the system more efficient and more productive. Although it will be difficult, I believe we can meet this challenge. Allow me to give you two examples of how efficiency can go hand-in-hand with quality.

You are, of course, familiar with the Mayo Clinic and its reputation for providing quality medical care. Many Americans do not realize, however, that the Mayo Clinic practices unusually efficient medicine as well. When caring for the resident population of Olmsted County, Minn., as opposed to referral patients, the Mayo Clinic has a hospitalization rate 30 to 40 percent lower than the national average for comparable populations. I should add that some of the larger, well-established HMO's have similar hospitalization rates.

Other studies suggest that increased efficiency can be combined with improved quality when certain complex surgical procedures—such as open heart surgery—are performed by fewer hospitals and physicians, with each providing a larger volume of services. Although the relationship between the volume of procedures performed and the quality of care is complex, the evidence seems to suggest that surgeons and other hospital staff learn by doing and thus increase their proficiency as the volume increases. At the same time, a high volume of procedures permits a hospital to spread its investment in equipment, facilities, and training over more patients, thus lowering costs per case.

I hope these examples will suffice to make a basic, but important, point: We need not abandon our commitment to quality health care in the name of making the health care system more efficient. On the contrary, we must make our health care system more efficient if we are to preserve and expand and enjoy the quality and access gains of the last several decades.

It is, of course, widely recognized that the sustained increase in health care costs is a serious problem. If we all recognize the need to be cost-conscious in the health care marketplace, why do costs continue to skyrocket? The answer comes down to basic economics.

Costs continue to rise because comprehensive, first dollar insurance too often hides costs from the view of both the patient and provider. Costs also continue to rise because private and public third-party payers have failed to act as prudent buyers of health services on behalf of their enrollees. Too often, the practice has been to pay virtually whatever is billed by physicians and hospitals, passing the costs on in the form of higher premiums or taxes.

We all recognize, of course, that the primary purpose of insurance is to spread the costs of illness so that concerns about the cost of care do not dominate our clinical decisions. Yet, it is possible to go too far, and the administration believes that the public and private health care financing system has gone too far in hiding the real cost of health care. Concealing costs to the extent we have has doomed the system to an inflationary spiral.

Many Americans feel that they are protected against rising health care costs because they have comprehensive insurance. Rising costs have, in fact, spurred many private health plans to add coverage to protect their enrollees against rising costs. This ignores, however, that adding more of the same kind of insurance does not reduce health care costs; it only hides them.

The end result is that the entire Nation pays for the high cost of health care but often in indirect ways: In higher employer-paid insurance premiums that reduce the financial resources available for increased wages and new jobs; in higher prices for goods and services to cover the elaborate health plans which are favored by our tax policy; and in higher taxes to support medicare and medicaid.

If we are ever to get control of health care inflation, we must correct the backward incentives built into our financing and delivery system. Federal health policy is a good place to start, because Federal tax and health programs have done much to hide health care costs and remove incentives for efficiency.

The package of health incentive reforms proposed by the administration for fiscal year 1984 will help slow inflation and encourage competition in the health care marketplace by creating economic incentives for providers and patients to control costs. Unlike proposals that merely attempt to cap the rise in health care costs through regulation of health care providers, the administration's package recognizes the need to provide complementary incentives for consumers. The administration's proposals call on all participants in the market for health services—doctors, hospitals, insurers, consumers, employers, and Government—to work together and share the responsibility for controlling costs.

Among the proposals included in the administration's package of reforms are:

The recently enacted prospective payment legislation that will switch medicare from retrospective cost reimbursement of hospitals to a system of prospectively determined payments.

A 1-year freeze on the fees that medicare pays physicians, which will slow the rise in medicare spending while HHS studies longer term reforms in physician reimbursement.

A proposal for restructuring medicare's hospital benefit that couples new catastrophic coverage with increased patient cost-sharing in the early days of a hospitalization.

A proposal to index the medicare part B deductible so that inflation does not steadily erode the deductible's value as a deterrent to unnecessary utilization.

A dollar limit on the tax-free contributions that employers can make toward employee health benefits.

The purpose of the administration's program is twofold.

First, the foregoing proposals would improve the medicare program so that it incorporates cost containment tools that have proven effective elsewhere: Reimbursement incentives and moderate patient cost sharing. By adopting these techniques for the medicare program, we believe the Federal Government would be providing a useful example for private health plans, as well as helping to assure the financial stability of the medicare program itself.

These changes in medicare would complement recent steps to improve medicare and medicaid. Legislation has already been enacted granting States much needed flexibility to make their medicaid programs more efficient. Using this authority, a number of States have launched interesting innovations, including efforts to steer medicaid recipients to lower cost providers. Important changes have also been made in medicare, including changes in HMO reimbursement that can be expected to increase the enrollment of medicare beneficiaries in HMO's.

The purpose of the proposed limit on tax-free private health insurance is to stimulate private plans to consider needed reforms in their own benefits and reimbursement rules. Since we feel there is not a single right way to improve the efficiency of a health benefits program, we would not require private plans to employ any particular cost containment technique. Instead, Government's proper role is to limit the tax law's distorting influence on private choices, leaving employment groups to develop cost containment programs tha suit their own needs. In short, the proposed tax cap is not a punitive tax on health benefits, but rather an effort to make the tax law neutral in the choice between added wages and added health benefits.

I am pleased to report that we are already seeing significant innovation in the design and management of private health benefits.

First, surveys indicate an increase in patient cost-sharing. According to the 1982 Hay-Huggins Survey of Noncash Compensation, about one-third of a broad sample of private firms had either recently increased their health insurance deductibles or were considering an increase. About one-quarter of the firms had recently increased patient coinsurance or were considering an increase.

The Rand health insurance experiment, which is financed by my Department, shows that cost-sharing can help control the cost of health care, particularly ambulatory care. One approach to getting workers to accept more cost-sharing is by rewarding them for doing so. For example, Du Pont recently offered its employees in Texas a choice of health plans: The original health plan, which has relatively low patient cost-sharing for basic medical and hospital care and no catastrophic limit on out-of-pocket costs, or a new plan, which couples more front-end cost-sharing with catastrophic coverage. Within 2 years, almost 50 percent of Du Pont's employees elected the second, more soundly structured plan. Du Pont is now planning to offer the same choice to all of its employees.

A second approach to private cost containment is the use of preferred provider organizations, PPO's. Under a PPO, the consumer retains a free choice of physician or hospital, although the PPO's sponsor, usually an employer, attempts to steer the consumer to lower cost providers who have signed participation contracts with the PPO. The employer steers the consumer by reducing his cost-sharing if he goes to a preferred provider. PPO's are particularly popular in the Western United States, where they are already stimulating price competition among providers seeking preferred status.

A related development is the continued growth of HMO's. As you know, HMO's vary in their organizational structure, but what they have in common is that they integrate health care financing and delivery to a greater degree than the traditional fee-for-service indemnity plans. Although the growth in HMO's has been steady rather than meteoric, it is encouraging that in those markets where HMO's are familiar to the public and where employers are supportive, HMO growth has often been significantly higher than elsewhere. General Mills, to cite one example, has 81 percent of its Minneapolis employees in HMO's.

Aggressive claims review is a fourth cost containment technique that is being used by a large number of employers. Rather than being passive payers of bills, private health plans are becoming cost-conscious buying agents for their enrollees. Because of their claims data and experience, plans are in a better position than individual consumers to identify marginal or unnecessary utilization. For example, John Deere's utilization review program has reduced the company's hospitalization rate by about 30 percent over a 30-month period.

A fifth encouraging development is the growth of employer-sponsored health promotion programs. For example, two large department stores have reduced their disability and hospitalization costs for hypertensive employees by 25 percent through a blood-pressure control program.

As you can see, Mr. Chairman, there is reason to be encouraged about the future. I believe these private sector efforts coupled with the recently enacted medicare prospective payment system and earlier improvements in medicaid represent a good start in slowing health care inflation.

Now, however, is not the time to rest. I hope Congress and the administration can build on the foundation that has been laid by reaching agreement on a package of reforms that stimulate still more consumer and provider efforts at cost containment.

As I have said earlier, and we all realize, the cost and the stakes are high. We need not abandon our commitment to quality health care in the name of making the health care system more efficient. But we must make our health care system more efficient if we are to preserve and expand the quality and access gains of the last several decades.

The CHAIRMAN. Thank you, Mrs. Heckler.

I have a number of questions which I will submit for your written comment later. I know you have to leave, but let me just ask you this: What are the consequences if the current health care cost trends continue unabated? Senator Kennedy has pointed out on his charts some of the problems.

Secretary HECKLER. Mr. Chairman, I would like to say that the consequences are truly alarming. I think, quite clearly, that unless further action is taken, our national health expenditures will continue their unrelenting climb, reaching about $750 billion in 1990, or about 12 percent of GNP.

As I have said in my prepared statement, health care expenditures currently amount to 10.5 percent of our GNP. In 1965 health care expenditures were only 6 percent of our GNP. The steady increase in the share of the GNP going to health care means that much less will be available for creating new jobs in other sectors of the economy and, similarly, less will be available for other necessary functions of the economy—food needs, education, housing, recreation, and other items that contribute very materially to our quality of life, health, and welfare.

The impact of the continued inflation will be even more dramatic for medicare. Projections are that under current law, medicare's hospital insurance trust fund will be insolvent in 1990 or shortly thereafter. This insolvency will occur despite the landmark prospective payment legislation that the administration and the Congress recently developed.

Unless we do something to slow health care inflation, the HI share of the payroll tax will have to be increased by 50 percent over the next 25 years. That is intolerable.

Alternatively, the program outlays would have to be reduced by 33 percent, also intolerable. Otherwise, the HI trust fund will become insolvent. So the seriousness of the problem is absolutely colossal.

[Responses of Secretary Heckler to additional written questions submitted by Senator Hatch follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUL 21 1983

The Honorable Orrin G. Hatch
Chairman, Committee on Labor
 and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your letter of June 13. Responses to additional questions for the record of the hearing on Health Care Costs are enclosed.

On behalf of Secretary Heckler, I would like to thank you for your kind remarks, and for giving us the opportunity to present our views on the pressing need to control rising health care costs.

Sincerely,

Thomas R. Donnelly, Jr.
Assistant Secretary for
Legislation

Enclosures

Q. Mrs. Heckler, what are the consequences if current health care cost trends continue unabated?

A. I will answer your question on two levels: What will happen to total national health expenditures and what will happen to Medicare, the Federal government's largest health care program.

Unless further action is taken, national health expenditures will continue their unrelenting climb, reaching about $750 billion in 1990, or about 12 percent of the GNP. As I said in my prepared statement, health expenditures currently amount to 10.5 percent of GNP. In 1965, health expenditures were only 6 percent of GNP.

The steady increase in the share of the GNP going to health care means that much less will be available for creating new jobs in other sectors of the economy. Similarly, less will be available for food, education, housing, recreation, and other items that contribute materially to the nation's health and welfare.

The impact of continued inflation will be even more dramatic for Medicare. The most recent report of the Medicare Trustees projects that, under current law, Medicare's Hospital Insurance Trust Fund be insolvent in 1990, or shortly thereafter. This insolvency will occur despite the landmark prospective payment legislation that the Administration and Congress recently developed.

Q. I am one who agrees that our present system of payment for health care has interfered with the operation of natural market forces and have contributed to the dramatic rise in health care costs. Since there are three basic approaches to altering the health market -- i.e., regulation, market-oriented approaches and voluntary private efforts, which of these three do you view as the proper direction?

A. General terms like "regulation," "competition," and "voluntary effort" often confuse the debate. Thus, I'd prefer to avoid those expressions in favor of less "loaded" terms.

The Administration believes that controlling the cost of private health plans -- for example, employment-based plans -- is a fundamentally private responsibility. As a result, we do not advocate hospital ratesetting programs that set rates for "all payors," both public and private. In fact, we believe that all payor ratesetting programs may ultimately discourage the sort of private sector initiatives that I described in my prepared statement. After all, employers, workers, and private insurers may wish to avoid the difficult and sometimes painful process of innovation if government is willing to assume responsibility for solving the problem.

It is important to note, however, that the Administration has not attempted to block State implementation of "all payor" ratesetting systems. As you know, we believe that States in a Federal system should have substantial discretion in implementing their own cost containment programs.

In contrast to its limited role in controlling private costs, the government's role in controlling Medicare and Medicaid expenditures is preeminent. Government must be a prudent, cost-conscious buyer in its capacity as insurer of the poor and elderly. For these public programs, government bears the primary responsibility for developing sound reimbursement and benefit policies.

Q. Most of the cost-related legislation considered by Congress now and in the past apply just to Federal programs, i.e., Medicare and Medicaid. How can we educate the general public regarding the need for cost-consciousness in their use of health care? Specifically, what changes does the Administration propose in all levels of our health care market to achieve such a goal?

A. As I indicated in my statement, we believe the "tax cap" -- or limit on tax-free employer-paid health insurance -- is the most important step we can take to enlist the private sector in the battle against health care inflation.

It makes little sense for the tax law to encourage elaborate health benefit plans that drive up health care costs. Yet that is what happens under current law, with the result that costs are higher for everyone, not just the people enrolled in the elaborate plan.

In our view, the tax law should encourage employers to offer an adequate level of benefits. But after some dollar threshold, the tax law should become neutral in the employee's choice between added health insurance and added cash wages.

Q. Do you anticipate that the recently enacted prospective payment legislation will affect the way hospital's provide services? Do you feel that this system will effectively reduce hospital costs and make hospitals more cost conscious in their delivery of care?

A. The prospective payment system will create strong new incentives for efficiency. I would expect, therefore, that hospitals will carefully review their services to determine whether they are able to provide those services within Medicare payment limits.

One result of this review may be increased specialization by hospitals, at least as far as complicated procedures are concerned. As I indicated in my prepared statement, specialization can permit hospitals to spread their fixed costs over a large volume of cases, thus lowering cost per case. Furthermore, specialization may improve the quality of care. As I said in my statement, hospitals providing a large volume of complicated services tend to become more proficient.

Prospective payment will also encourage better communication between hospital administrators and physician staff, as well as better communication within the physician staff. Better communications will be imperative if hospitals are to be able to stay within the Medicare limits.

One effect of improved communication will be better coordination of lab tests and other diagnostic procedures to avoid unnecessary duplication. The evidence suggests that such an improvement has begun to occur under New Jersey's DRG system.

Q. What is the current status of the work of the Bowen Commission on Medicare?

A. By law, the Bowen Commission must report before January 1, 1984. It is too early to predict when the report will actually be filed.

For your information, I am attaching a copy of the Bowen Commission's policy recommendations through June 1983.

ADVISORY COUNCIL ON SOCIAL SECURITY

Policy Recommendations
(Through June 1983)

SUMMARY

1. General Revenue Contributions to the Hospital Insurance Trust Fund

The Council opposes any increase in the use of general revenues (i.e., income to the Treasury not earmarked for a specific purpose) to finance the Medicare Hospital Insurance (HI) trust fund. The HI program should continue to be funded primarily through specified payroll contributions by employers, employees and the self-employed.

2. Interfund Borrowing

The Council believes that the individuality of the Old Age and Survivors Insurance (OASI), Disability Insurance (DI) and Hospital Insurance (HI) programs should be maintained, and that each program should be funded at a level sufficient to meet its continuing needs. Where short term interfund borrowing among the trust funds is deemed necessary, such borrowing should be subject to appropriate safeguards which include authority for each fund to borrow from the others, specific repayment schedules and prohibition against reducing the lending fund's assets below an actuarially acceptable level.

3. Prospective Payment

The Council endorses the principle of prospective payments for Medicare inpatient hospital services. The Council supports a prospective payment system based on diagnosis provided it is equitable for all hospitals, encourages efficiency of operations and maintains accessibility and quality of care for Medicare beneficiaries. (This recommendation was enacted in Social Security Amendments P.L. 98-21.)

4. Universal Social Security Coverage

The Council concurs with recommendations by the National Commission on Social Security Reform (1) that Old Age, Survivors, Disability and Hospital Insurance (OASDHI) coverage be extended on a mandatory basis to employees of nonprofit organizations, and (2) that State and local government units which have elected OASDHI coverage for their employees should not be permitted to terminate such coverage in the future. (These recommendations were enacted in Social Security Amendments P.L. 98-21.)

5. Diagnosis and Treatment Related Coverage Under Medicare

The Council opposes any further extension of Medicare coverage to individuals (not otherwise eligible based on age or disability status) on the basis of medical diagnosis or the medical necessity for a particular form of treatment. Should specific categories of disease be considered in the future for federal financial assistance, such assistance should be provided through a special program with separate allocation of funds to pay for the required treatment.

6. Assignment of Medicare Benefits for Physicians' Services

The Council recommends a revision to the current Medicare assignment system. The revision would establish a physician participation agreement system under which physicians would annually elect whether they would "participate", i.e., accept assignment on all services to Medicare patients. Notice of intent to participate or to withdraw from participation would be made 6 months in advance. Claims for reimbursement for services furnished by physicians who decided not to participate would always be unassigned, and program payment would always be made to the patient who would be responsible for the physician's entire bill including any amount that exceeds Medicare's reasonable charge. Special incentives would be provided for physicians to participate.

The incentives recommended by the Council include:

a. Competition: The Medicare program would publish annually a directory of participating physicians. The directory would be published on a local basis, e.g., city, county or Standard Metropolitan Statistical Area (SMSA), as appropriate.

b. Billing: Participating physicians could take advantage of streamlined billing and payment procedures. Such incentives could include provisions for multiple-list claims, automated or electronic billing with the program providing some of the necessary equipment and an electronic funds transfer (EFT) payment process.

The Council is also considering provision of reimbursement incentives under which services of participating physicians would be reimbursed at a higher rate than services of nonparticipating physicians. Additional cost data are being developed.

7. Funding Crisis of the Hospital Insurance Trust Fund

The Council recognizes that one of the most critical problems facing the Medicare program--in both the short range and long range--is the projected insolvency of the Hospital Insurance (HI) Trust Fund. Anticipated outlays in excess of income are expected to fully deplete that fund by the beginning of the next decade. Over the longer run, the Council recognizes that at least $200-$300 billion in additional income or decreased outlays will be required to keep the trust fund solvent through 1995. Any recommendations for eliminating this deficit should include long term revisions that assure that savings or increased revenues continue in the out-years. In developing recommendations for assuring fiscal soundness of the Hospital Insurance program, the Council will seek long term reforms which assure the continued viability of the program and adequate access to affordable health care for beneficiaries.

8. Summary of Advisory Council Decision on an Enhanced Part A and B Medicare Package Financed by Actuarially Sound Premiums

The Council recommends a restructuring of the Medicare program to provide for an enhanced Medicare Part A benefit and a $200 yearly limit on Part B out-of-pocket expenses. The Council also tentatively recommends an additional $60 per year premium charge for the purpose of providing additional program revenues necessary to contribute to the reductions of projected trust fund deficits expected to occur by the end of this decade. This issue will be reconsidered by the Council after it receives additional information on revenues that could be realized with other premium amounts.

Although the premiums necessary to support these enhanced Medicare benefits will increase the current Part B Supplementary Medical Insurance premium, the total premium will be substantially less than the premium most Medicare beneficiaries now pay for Medicare Part B and private "Medigap" insurance. However, the Council emphasized that although they have approved the premium concept, they intend to address the issue of what can be done for low income individuals who may be unable to afford the higher premium.

9. Summary of Advisory Council Decision on Increasing the Age of Eligibility for Medicare Benefit

Increase the age of eligibility for Medicare from 65 to 67, but schedule the increase earlier than called for in the recent legislation (1983 Social Security Amendments) increasing the age of eligibility for retirement benefits. The increase would be implemented in 1990, and will increase the age of eligibility 2 months a year over a 12 year period.

The following table shows the estimated savings that would result from the above increase in age of eligibility. All figures are in billions of dollars and are based on the 1983 Trustees Report Alternative IIB Assumptions.

Calendar Year		Calendar Year	
1990	$ .6	1999	$11.1
1991	1.3	2000	13.2
1992	2.1	2001	15.6
1993	3.0	2002	17.2
1994	4.0	2003	18.8
1995	5.2	2004	20.8
1996	6.4	2005	23.0
1997	7.7	2006	25.5
1998	9.3	2007	28.4

Q. Does the existence of multiple options in the FEHBP result in higher or lower health care costs per capita than for the nation as a whole?

A. There is insufficient information to make a direct comparison. Historic information on the FEHBP includes only premiums and enrollment. There are no data on total expenditures including out-of-pocket costs. Further, we cannot control for differences in demographic mix (age-sex categories) or changes in insurance benefit coverage over time.

Claims of savings for the FEHBP are based on two arguments, both supported by empirical research. First, the availability of multiple options allows FEHBP enrollees to select fee-for-service plans with more cost sharing than the average employment-based plan requires. The savings in total health care costs (insurance premiums plus out-of-pocket expenditures) in the FEHBP in 1983 attributable to the larger number of enrollees taking low option plans with higher cost sharing is estimated to be $90 to $150 per family, about 3 percent to 5 percent of average family cost. The projection is based on considerable behavioral research which shows that, on average, people lower their utilization of health care in response to higher cost sharing. Second, savings occur because an active multiple choice system like the FEHBP encourages enrollment in prepaid health care options. The FEHBP has been successful in this regard, with over 11 percent of its enrollees in HMOs, compared to a national average of 5 percent. Savings attributed to enrollment in an HMO have been estimated in various studies at 10 to 40 percent.

Q. What has happened to FEHBP plan enrollments in response to premium and benefit changes?

A. Since 1973 the market share of Blue Cross High Option, the most popular plan, has been decreasing. The enrollment trend has been away from the government wide options -- Blue Cross High and both Aetna options -- to Blue Cross Low, the employee organization plans, and the comprehensive health plans/health maintenance organizations (HMOs). The 31 percent increase in average premiums and benefit cuts of 12 to 16 percent for 1982 accelerated those trends (see accompanying tables). The major winners with respect to new enrollment in 1982 were Blue Cross Low Option (+12.9 percent), Mail Handlers, (+84.0 percent) and National Association of Letter Carriers (+23.5 percent).

More detailed information on plan switching during the May, 1982 open season is available for Department of Health and Human Services employees in the Washington, D.C./Baltimore area. This data shows that the movement was generally to lower priced plans. Those enrollees who switched from one family option to another managed to lower their average annual contribution from $959 to $607 or by $352 per year. For those who switched from one self-only option to another, the average annual contribution fell by $178, from $442 to $264. (These savings were calculated by comparing the 1982 premium of the new plan with the 1982 premium of the prior plan.)

The savings were achieved by accepting more cost sharing, enrolling in HMOs with more stringent utilization controls or by locating plans which offer the same benefits but at a lower premium. The latter occurs if the new plan is administered more efficiently, or includes an above average share of enrollees with low risk or who are located in low cost areas.

Q. Does the pattern of plan changes in the FEHBP suggest that adverse selection in a free choice system may affect costs adversely?

A. Recent experience in the FEHBP illustrates the value of free choice to enrollees and the potential for improved performance. During the past two open seasons a substantial share of enrollees sought relief from large increases in employee contributions to premiums by switching to plans with more cost sharing or more stringent utilization controls.

The results of previous research suggest that the average utilization of those who switch to less generous plans will be lower than if they had remained with their original options. Only a multiple choice system allows a group of enrollees to submit voluntarily to more stringent controls without forcing others to comply with the change.

Competitive choice provides a market test of different plans and may yield even greater savings in the long run. If the difference in premiums of plans grows over time, more enrollees may select lower price plans or similarly priced plans with more services unless the high premium plan is restructured. In either case, more cost controls result. Just as importantly, a multiple option system encourages competition for quality, accessibility and content of care as well as price.

Research results indicate that adverse selection is a potential problem for high cost plans in some multiple choice health plans. However, the rise in per enrollee claims reflects a redistribution of risks across the various insurance options, not an increase in utilization by enrollees. Total program costs do not increase as a result of self selection of risks into different plans.

The FEHBP is not an ideal model of competition and certainly not the only model. But the program has demonstrated the feasability of competitive multiple choice of health plans for almost 25 years.

Table 1

Federal Employee Health Benefits Program
Summary of Enrollment
(in thousands)

	1970	1975	1980	1981	1982
Blue Cross High	1432.2	1724.4	1525.0	1503.6	1237.5
Market Share	53.6%	54.8%	42.4%	40.9%	32.2%
Blue Cross Low	179.4	234.5	312.3	316.3	357.1
Market Share	6.7%	7.5%	8.7%	8.6%	9.6%
Blue Cross Total	1611.6	1958.9	1837.3	1819.9	1594.6
Market Share	60.4%	62.2%	51.1%	49.5%	42.8%
Aetna High	346.8	342.2	356.1	335.9	333.7
Market Share	12.9%	10.9%	9.8%	9.1%	8.9%
Aetna Low	147.4	132.4	118.2	115.3	102.0
Market Share	5.5%	4.2%	3.3%	3.1%	2.7%
Aetna Total	494.2	474.6	474.3	451.2	435.7
Market Share	18.5%	15.1%	13.2%	12.9%	11.7%
Total Govt. Wide	2105.8	2433.5	2311.6	2271.1	2030.3
Market Share	78.8%	77.3%	64.2%	61.8%	54.5%
Total Employee Association	389.8	475.2	928.4	1026.0	1267.2
Market Share	14.6%	15.1%	25.8%	27.9%	34.02%
CMP/HMO	176.2	242.3	356.2	380.4	427.4
Market Share	6.6%	7.7%	9.9%	10.3%	11.4%
TOTAL	2670.1	3146.7	3598.4	3677.6	3724.8

SOURCE: Federal Fringe Benefit Facts

Table 2

Federal Employee Health Benefits Program
Summary of Enrollment Changes Between 1981 and 1982

Popular Plans and Plan Groups Enrollment
(in thousands)

	1981	1982	Change	% Change
Government Wide Plans				
Blue Cross High	1503.6	1237.5	(266.1)	(17.7)
Blue Cross Low	316.3	357.1	40.8	12.9
Aetna High	335.9	333.7	(2.2)	(0.7)
Aetna Low	115.3	102.0	(13.3)	(11.5)
Total Govt. Wide	2271.1	2030.3	(240.8)	(10.6)
Six Popular Employee Organization Plans				
Alliance	91.8	62.1	(29.7)	(32.3)
APWU	214.8	191.4	(23.4)	(10.9)
GEHA	120.5	118.6	(1.9)	(1.6)
Mail Handlers	153.5	282.4	128.9	84.0
NALC	187.8	279.5	91.7	48.8
Postmasters	81.6	79.5	(2.1)	(2.5)
Total Employee Organization Plans	1026.0	1267.2	241.2	23.5
CMP/HMO	380.4	427.4	47.0	12.4
TOTAL	3677.6	3724.8	47.2	1.3

SOURCE: Federal Fringe Benefit Facts

Q. What are the implications of health care cost strategies which address only Federal programs?

A. The Federal government's appropriate role is to limit the inflationary impact of Federal tax and spending policies. We do not believe the Federal government should assume responsibility for controlling the cost of private health plans. The Federal government should focus its efforts on the Federally-financed health programs, leading the private sector by example, not by fiat.

There is no single "right way" to finance and deliver medical care. Therefore, we should permit private firms and the States to experiment with a broad range of cost containment techniques. Through that experimentation, we can learn more about which techniques succeed in slowing inflation.

Critics of our approach argue that it promotes the "shifting" of costs from the Federal budget onto private payors -- particularly, hospital costs. This criticism assumes, however, that private payors must passively accept hospital efforts to shift costs, when in fact private payors can avoid cost shifting. The most important step a private plan can take is to reduce the rate of hospitalization among its enrollees, yet private insurers have barely begun to explore the possibilities.

As you know, many HMOs and some fee-for-service arrangements (like the Mayo Clinic) have reduced hospitalization dramatically -- up to 30 to 40 percent below the national average -- without hurting the quality of care. All private payors should be trying to emulate this performance.

Wherever possible, private payors should also question what hospitals charge them. One way a private payor can increase its financial leverage so that hospitals must "listen" is to establish a "preferred provider organization" (PPO). Under a PPO, a private payor can offer to steer its enrollees to a given hospital if the hospital charges reasonable rates.

Q. To what extent should the Federal government actively encourage the development of HMOs?

A. The Federal government should be moving toward a position of neutrality toward HMOs. Federal financial subsidies should be phased out, as the Administration has proposed.

We believe HMOs are able to pass the "market test" without government subsidies, and the investment community seems to share our confidence. In recent months, there has been a dramatic increase in investor interest in HMOs.

One role the Federal government should play is to educate investors about the HMO industry. To that end, the HHS Office of HMOs has sponsored workshops and publications on investment opportunities in the HMO industry.

Q. With the shift of payment to a per case basis rather than a cost reimbursement basis, what will hospitals do to pay for their uncompensated care costs?

A. The implicit premise of this question seems to be that the Medicare schedule of payments per case will be too low to cover the full cost of care. We do not accept this premise. We believe that the Medicare payments will be adequate to compensate hospitals for efficiently provided services.

It is true that some hospitals will have to change how they provide care if they are to stay within the DRG-based payments. But that is exactly as it should be. Not all hospitals are equally efficient; some are clearly inefficient.

It is also true that Medicare's prospective payment system will not include payment for bad debts resulting from care for non-Medicare patients. In our view, Medicare payments for non-Medicare patients would be inconsistent with the goal of the Medicare program: to finance health care for the elderly and the disabled. Furthermore, such payments would be a further drain on the already strained Medicare Hospital Insurance Trust Fund.

Q. Should health care reforms take place at the Federal level, or should States and/or localities be allowed, indeed encouraged, to develop their own approaches to restraining health care costs?

A. [Note: This question addressed in answering the question about "federal-only" cost containment efforts.]

Q. How should capital expenditures and the allocation of resources be dealt with under a health care cost strategy?

A. Improved reimbursement mechanisms are the best way to improve the allocation of capital resources. Under cost reimbursement, there has been little incentive for providers to consider their capital investments with care. The inevitable result has been duplication and inefficiency.

The Medicare prospective payment system and other private reimbursement reforms will dramatically change the capital investment market. Providers will need to consider how investments will affect their operating costs per case, and thus their ability to compete.

These financial incentives for careful investment will increase in the future. As you know, capital costs (e.g., interest and depreciation) will be reimbursed on a cost basis during the initial phase of Medicare's prospective payment system. But at Congress' request, HHS is now studying ways to incorporate capital into the Medicare prospective payment system. We will report to Congress by October 1, 1984, the deadline established in the Social Security Amendments of 1983.

Assuring efficiency in capital investment is a reimbursement issue, not a health planning issue. No amount of health planning can substitute for appropriate incentives in reimbursement. Thus, the Administration continues to oppose Federal funding for health planning and certificate-of-need regulation.

Q. Do you think there needs to be a bipartisan Medicare Commission, like the Social Security Commission, in addressing the projected deficits in the Health Insurance Trust Fund?

A. A nonpartisan commission is now studying the issue: the Quadrennial Social Security Advisory Council, chaired by Dr. Otis Bowen, former governor of Indiana.

The "Bowen Commission," which was appointed by former HHS Secretary Schweiker, must report to Secretary Heckler by January 1, 1984.

We believe it would be premature to appoint another commission before the existing one has even reported.

Q. Some economists believe that prospective payment should be applied to other providers, such as doctors. Is this a good idea? Is it feasible?

A. The Social Security Amendments of 1983 require HHS to study the feasibility and advisability of making physician payments for inpatient services based on a DRG classification system, like the one established for hospital payments. HHS must report back to Congress in 1985.

Whether this is the best approach for increasing physician incentives for efficiency should be decided after the study is complete. The need for improved incentives for physicians is clear, however.

Q. I am concerned with the equity of the tax cap proposal, especially what effect it will have on low-income workers and small businesses. What parts of the population would be most affected?

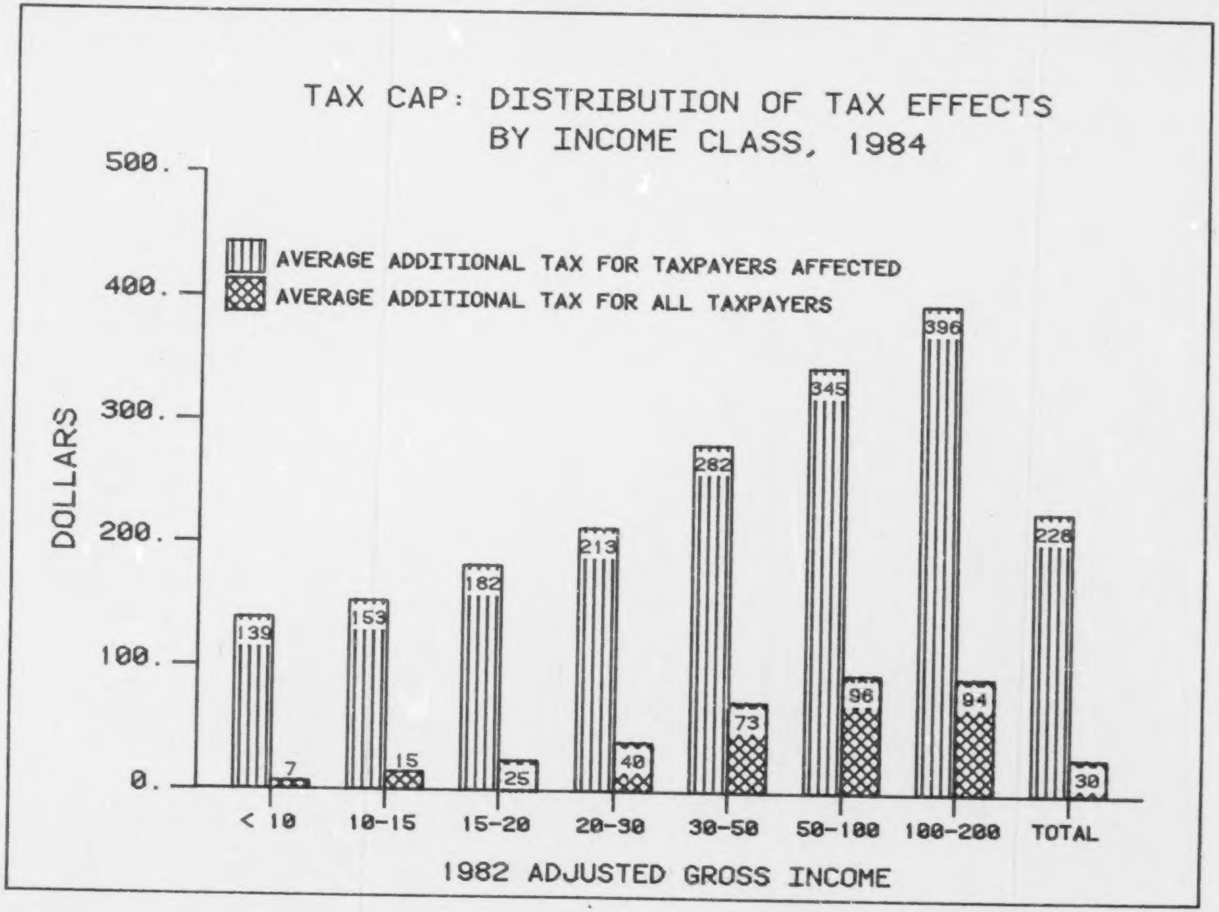
A. The proposed limit on tax-free health insurance -- the so-called "tax cap" -- would have little impact on low-income workers. The attached chart shows the average tax increase by income class.

As you can see, the added tax burden is directly related to income. The tax burden rises with income for two reasons: (1) low-income workers are significantly less likely to have health benefits exceeding the proposed cap of $175 per month per family and $70 per month per individual; and (2) any "excess employer contributions" will be taxed at a lower rate for low-income people since the income tax system is progressive.

As shown in the chart, the average taxpayer in the $10,000 - $15,000 income class would pay only $15 in added taxes in 1984 under the Administration's proposal. If one considers only those taxpayers in $10,000 - $15,000 income class with health benefits exceeding the cap, the average tax increase would be $153 in 1984. The vast majority of taxpayers in $10,000 - $15,000 income class would pay no new taxes at all in 1984.

The evidence also indicates that employees of small firms would be no more likely to exceed the $175/$70 cap than the average worker. In general, small groups have less comprehensive coverage than larger groups.

The proposed tax cap would have the greatest effect on large employment groups with above average income. These groups are the most likely to have comprehensive, "first dollar" insurance and coverage for a wide range of supplemental benefits, for instance vision and dental insurance. Even these groups can significantly reduce their tax laibility, or possibly avoid taxes altogether, by undertaking reasonable cost containment steps, including moderate patient cost sharing, tighter utilization review, and preferred provider arrangements.



TAX CAP: DISTRIBUTION OF TAX EFFECTS
BY INCOME CLASS, 1984

Q. Dr. Rubin, as a physician, would agree that some, in fact most, technology is cost effective and the cost problem results only when the technology is overutilized?

A. It is certainly true that many new machines or procedures have potential for reducing some types of costs. The much-maligned CAT scanner is an obvious example. When properly used, the CAT scanner can obviate the need for surgery or more invasive testing.

The problems arise when CAT scanners and other pieces of sophisticated, and expensive, technology are used carelessly or used when less expensive techniques would serve the same purpose. Rather than simply limiting the supply of new technology, we should be changing the reimbursement system so that providers have an incentive to use technology more carefully. That, of course, is one of the goals of the Medicare prospective payment system and of a variety of innovations in private health care financing.

We should not permit our frustration with health care inflation to breed an anti-technology impulse. The technology is not the problem; the problem is our financing system.

Q. To what extent is the increasing supply of doctors generating competitive forces in the marketplace? Should the Federal government continue to supply money to train these professionals?

A. The increasing supply of physicians is stimulating price competition among physicians. In fact, the much-publicized growth of preferred provider organizations (PPOs) is symptomatic of that competition.

Employers and other large purchasers of health care see PPOs as a tool for forcing physicians to compete on the basis of price. Unless a physician is willing to discount his or her fees and submit to certain utilization controls, the employer will use economic incentives to steer its patients to other physicians. Physicians, and other health care providers, agree to the employer-established limits because they want an assured flow of patients. The larger the supply of physicians and other providers, the more willing physicians are to compete to become "preferred" providers.

Although the stiffest price competition is in urban areas with the densest concentrations of providers, other regions benefit indirectly. A Rand Corporation study has documented the increasing supply of board-certified physician specialists in non-urban areas. The study suggests that stiffer competition in urban markets may be one of the factors responsible for this trend. (Schwartz, Newhouse, et.al., "The Changing Geographic Distribution of Board-certified Physicians," New England Journal of Medicine, vol. 303 (October 30, 1980), p. 1032).

As a standard part of the development of the FY 1985 budget, HHS is now reviewing its policy toward manpower training. Under the FY 1984 budget, the Department proposed to spend approximately $120 million on health professions training. The major programs include:

- Primary care training: ($54 million) This program supports grants designed to encourage an adequate supply of primary care practitioners by supporting the development of Departments of Family Medicine, and residencies and faculty development in Family Medicine, Pediatrics and General Internal Medicine.

- Area Health Education Centers: ($15 million) This program provides funds to medical and osteopathic schools for the purposes of decentralizing education by having portions of training provided in shortage areas and by improving the coordination and use of existing health resources.

- Student Assistance: The Department guarantees loans under the Health Education Assistance Loan (HEAL) program and provides oversight for loans administered by schools under the Health Professions Student Loan (HPSL) program.
- Disadvantaged Assistance: ($18 million) This program provides funds to improve opportunities for minorities and disadvantaged students to enter health professions training.
- Nurse Training: ($13 million) These programs support grants for Advanced Nurse Training, Nursing Special Projects, Nurse Practitioner Training and Nursing Student Loans.

Q. During the debate on Prospective Payment, it came to my attention that 111 of the 467 DRGs were found to have a sample size too small to guarantee statistical signficance. It is my understanding that when these rates are published in the Federal Register, a note will describe this problem. Is this correct?

A. The Federal Register will contain a thorough explanation of how we compute relative weights for these low incidence or empty DRGs.

Q. Critics of the Medicare voucher proposal say aged and disabled populations are often unable to make informed choices about coverages or the use of health care. What is the success rate of current demonstrations using Medicare vouchers?

A. Under current law, Medicare beneficiaries must make important and sometimes complicated choices on what medical services they need and what insurance coverage ("Medigap") to purchase. The need for careful decisions is not unique to the Medicare voucher proposal.

In fact, one of the benefits of the voucher program is that it would make it easier for a Medicare beneficiary to enroll in an organized system of health care financing and delivery as an alternative to the more fragmented fee-for-service system. An organized system can help assure appropriate access to care, provide necessary referrals, and protect against unnecessary utilization that might prove expensive to the beneficiary. In short, an organized system can help guide the beneficiary through a complicated health care system.

It is also important to remember that, under the Administration's voucher proposal, beneficiary participation would be voluntary. Thus, the beneficiary would always have the option of remaining in the traditional Medicare program.

The only demonstration evidence on how well beneficiaries can make decisions among competing private health plans comes from demonstration projects under which beneficiaries were permitted to enroll in HMOs. Perhaps the best measure of the participating beneficiaries' choices is the beneficiaries' apparent satisfaction with their enrollment decisions. Only 3-5 percent of the beneficiaries enrolling in HMOs voluntarily disenrolled, and some of that disenrollment is attributable to beneficiaries' changing residences.

The **Chairman**. Mrs. Heckler, what time do you have to leave?

Secretary **Heckler**. I have to leave at about 10:45.

The **Chairman**. If we could each limit our questions—Senator Kennedy, let's turn to you next. Dr. Rubin, I understand, is going to stay, so we can ask——

Secretary **Heckler**. Dr. Rubin will be available to respond to questions.

Senator **Kennedy**. Welcome, Madam Secretary.

With respect to increasing cost consciousness, which is a theme of your presentation, can you give us some idea of how your program will affect each of the relative income groups, just in broad categories—lowest income group, middle income group, and highest income group?

Secretary **Heckler**. Are you speaking of the prospective payment proposal, Senator?

Senator **Kennedy**. Through additional copayments, which is the primary instrument by which the administration has been talking about, cost-sharing. You referred to the Rand study and the reduction in ambulatory care—of course, increased cost-sharing is going to keep people from going to doctors. We do not need a study for that. Poor people, low-income people will not be going to doctors. I think that is the problem that concerns me.

The very wealthiest are going to be able to buy insurance that is going to cover those copayments. Low-income groups are not. You are going to reduce the number of visits to the doctors on their part, but that has an important impact in terms of preventive health care and also in primary care.

I am just interested in your view about that—whether you are bothered by it, whether you are troubled by it, whether you agree with my general observation and how the administration intends to deal with it.

Secretary **Heckler**. Well, Senator, it is quite obvious that we are dealing with a skyrocketing, spiraling health care component in our economy. We feel very strongly that we can preserve the quality of health care while requiring more efficiency in the health care delivery system.

We have had a number of studies at the Department which indicate that certainly the quality of care will not be diminished in any way. As I mentioned in my statement, the Mayo Clinic, one of the most celebrated medical institutions in the country, has a much lower hospitalization rate for the average patient than is generally the case, despite the fact that it is well known for its quality.

Now, in speaking to your specific question, on cost-sharing, the medicaid patient—that is, the poorest of the poor—will be fully protected. The administration is proposing very nominal copayments, which are expected to be about $12 a year. I would not consider that to be an inhibiting factor, by any means, if you just compare it to the cost of a carton of cigarettes.

In terms of medicare, there will be a definite increase in the initial upfront cost to the medicare patient, estimated under our proposal to be about $280 a year. At the other end of the spectrum, the medicare patient will be relieved of probably the greatest anxiety, which is this catastrophic cost, which could wipe out all their savings.

As I have mentioned, in the private sector when individuals were offered the opportunity to have a greater cost sharing initially in return for catastrophic coverage at the end they opted for higher upfront costs in return for the catastrophic coverage, so that concern would be removed from them.

Senator **Kennedy**. I think we are allowed to ask only one question, but this is just a continuation on this. [Laughter.]

The fact is you are talking about people with fixed incomes, and increasing the cost-sharing for people with fixed incomes who do not have the elasticity puts a very significant burden on them.

I will be glad to go over in detail your own studies on that of what the impact is going to be in terms of quality care. You just cannot convince me that keeping more people, particularly elderly people, away from the doctors when they have some need is going to be in their interest in terms of the health care costs. You are talking about fixed incomes, low-income people. You are going to keep people away who are in need.

With regard to your proposal for the catastrophic coverage, you know as well as I that you are talking about helping less than 2 percent of the people who go to the hospital. Basically, the catastrophic is a bailout for the hospitals.

On your proposal to freeze medicare payments to physicians, you fix the amount that is going to be reimbursed to the doctors by medicare, but you are going not to put any limitation on what the doctors are going to be able to collect from the patients. Therefore, they will just raise the amount that is going to come from the patient. It will reduce what is shown in Government expenditures, but it will come out of the pockets of the patients and the elderly people.

If you had said: "Look, we'll require physicians to take assignment and take that as payment in full," which I think would be a bold action by your Department——

Secretary **Heckler**. Yes, it would.

Senator **Kennedy** [continuing]. But I think you might really get a handle on the cost.

I want to thank you. We will continue, I am sure, with this discussion.

The **Chairman**. Mrs. Heckler, you are 3 minutes over. When you have to leave, someone will let you go. Dr. Rubin is here. He can answer our questions.

Senator **Quayle**. Mr. Chairman, before she goes, may I ask a question?

Secretary **Heckler**. Senator, I do have to leave.

However, I do have one statistic I would like to present to Senator Kennedy, which is simply that the share of health expenditures that the elderly pay from their private resources has dropped from 39 percent in 1970 to 36 percent in 1981.

Senator **Kennedy**. Madam Secretary, you know as well as I do that the elderly people are now paying more out of pocket today than when medicare was passed. Under the recommendations of the administration, that is going to increase. The percent that is not covered by the medicare has increased.

I will be glad to look at that and to study the figures, but—I think I might have even heard you say that back in Massachusetts some time ago. [Laughter.]

The CHAIRMAN. I don't want you quoting some of the things that he has said, though.

Secretary HECKLER. Aha. [Laughter.]

Senator, I just would say that I stand behind the studies of the Department because I do think they are solid and verifiable, and this information is available.

The CHAIRMAN. We are going to permit one more question.

Senator Quayle.

Senator QUAYLE. I have just one quick question.

As you know, Madam Secretary, we are getting ready to proceed with health benefits for the unemployed. David Stockman testified before this committee.

I would like your observation and input as to which block grant or which program we ought to put the monies in. There seems to be a dispute as to whether or not we ought to go with the social services block grant or the health block grant. I would certainly think that from your position that there may be some advantage to go to the health block grants, notwithstanding the financial situation.

We will endorse the theory that the administration has that you have to pay as you go, but your whole statement here was a lot on efficiency, and certainly does not seem as though it would be a very efficient manner for us to put that money into social services block grant.

I would like to have your response to that.

Secretary HECKLER. Senator, as you know, the administration proposal, as expressed by David Stockman in his testimony, does allow for an increase in funding under a block grant approach, however, on the stipulation that the increased costs are offset by a reduction elsewhere. This is not, in the administration's view, to be a new addition to the budget. It is to be a budget neutral item. I would just like to make that point.

Senator QUAYLE. I understand. The point is perfectly clear.

My question and my concern is, Which block grant are we going to put these funds in? I would think from an efficiency point of view that you stressed this morning, and from a managerial point of view, that would make far more sense to put this in a block grant dealing with health than putting it in a social services grant that deals with health care, which I believe is somewhat unrelated.

I would just like your comment as Secretary of this whole area. I would encourage you to advocate that particular position because we are going to be going forward in this committee, the Finance Committee, the Commerce Committee, and Ways and Means. There are going to be a lot of committees, and I think that beyond the revenue neutrality issue, which I accept, what the argument is, is where this thing is going to go. I think you have a lot at stake, being Secretary of HHS, on where these funds are going to go. I hope that internally, and perhaps publicly, you will come forth and say that, for certain reasons, efficiency and others, that it ought to be in the health care block grants.

Secretary HECKLER. The general thinking has been to have the program funded through budget neutral process—and I stress that because it is absolutely an underlying requirement—that the funding in general discussions has usually been generally attributed to, an addition to the social services block grant, as you know.

Now I think a case can be made for choosing another block grant, and I really feel the decision is set in cement on that question.

Senator QUAYLE. As just one Senator concerned on this committee, I would encourage you, as the responsible party for the health issues concerning this country, to take a very strong internal role in this in trying to advocate where the best place for these funds is. I can understand the strategy at least to start out with the social services block grant, but I think, once you think it through, you are going to find that that is a very inappropriate place to put these funds when the Congress goes through it. I just bring that to your attention and ask your assistance on that.

Secretary HECKLER. I shall take it under advisement.

The CHAIRMAN. Thank you, Mrs. Heckler. We will allow you to go. We have questions for Dr. Rubin.

We are also going to submit questions because it is clear that a lot of us have a lot of questions. With all the witnesses we have today, we do not have time to ask every question orally.

We will have a 5-minute rule. If we have to come back, we will go back and forth.

Dr. Rubin, let me just ask you a couple questions here this morning.

Thank you, Mrs. Heckler, for coming. We appreciate it. We appreciate the work you are doing.

Secretary HECKLER. Thank you.

The CHAIRMAN. Dr. Rubin, what are the implications of health care cost strategies which address only Federal programs?

Dr. RUBIN. Senator, the President's health incentive reform package, which was sent up to the Congress at the end of February, addresses not only the Federal sector of medicare and the Federal-State sector of medicaid, but also deals with the private sector through the imposition of a dollar limit on tax-free employer contributions to health insurance.

Clearly one has to address the private sector as well as the public sector—

The CHAIRMAN. And you feel you are doing that?

Dr. RUBIN. Yes, sir.

The CHAIRMAN. How should capital expenditures and the allocation of resources be dealt with under a health care cost strategy?

Dr. RUBIN. Under the medicare prospective payment system, as you know, we have been asked by the Congress to look at methods of incorporating capital into the fixed price that we are going to pay hospitals. We think that certainly is one thing that eventually will help to promote efficiency in capital investment.

People also forget that for every dollar's worth of capital expenditures, there is an increase of about 30 cents in operating expenditures. Again, under the prospective payment, we are currently limiting operating expenditures, so I believe that hospitals will be encouraged to be cost effective in their capital allocation decisions.

The CHAIRMAN. In your proposal for capital expenditures and allocation of resources, what is your proposal for health planning?

Dr. RUBIN. If health planning were an effective tool for preventing unwarranted capital expenditures, then we would support it. There is a large body of evidence, however, that suggests that health planning as envisioned under the health planning law has not been effective. Therefore, we seek no funds for health planning. The administration's position on this issue has been clear and consistent.

We believe that the market efficiently allocates capital when appropriate public and private reimbursement mechanisms are established. Medicare prospective payment is a major step in that direction. I think that capital is best viewed as a reimbursement issue rather than a Government planning issue.

The CHAIRMAN. Do you think that there needs to be a bipartisan commission with regard to medicare, a bipartisan medicare commission like the Social Security Commission, in order to resolve these difficulties and address the projected deficits in the health insurance trust fund?

Dr. RUBIN. I do, but there is such a commission. As you know, former Gov. Otis Bowen is chairing the Quadrennial Advisory Council on Social Security, a bipartisan commission, required by law that is studying the long-term future of medicare. The Bowen Commission must report to the Secretary prior to January 1, 1984.

The CHAIRMAN. I have other questions, but let me turn to Senator Kennedy.

Senator KENNEDY. What evidence do you have that the capping of the medicare reimbursements is not resulting in cost shifting within the hospitals and to other sectors of the health care system, or do they? Are you seeing that now?

Dr. RUBIN. Senator, "cost shifting" is an interesting term that has been overplayed to some extent.

As you well know, medicare pays 100 percent of medicare-allowable costs and 100 percent of medicare bad debts. What is this cost shifting all about? About five medicare reimbursement rules account for roughly two-thirds of the cost shifting.

One is that the Federal Government does not pay for unsponsored research conducted in hospitals.

Senator DENTON. For what?

Dr. RUBIN. For unsponsored research. The reason medicare has not paid for such research in evident to all the members of this committee—the Federal Government pays for much of the sponsored research through NIH, to the tune of about $4 billion a year.

A second element of the alleged cost shift is that the Federal Government does not pay for nonmedicare bad debts—that is, bad debts attributable to private patients.

Third, we have not paid the use of TVs and telephones in patients' rooms, which of course private insurance companies do.

Fourth, we have not paid the share of malpractice premiums that is attributable to the malpractice claims of nonmedicare patients.

Fifth, medicare has not reimbursed hospitals for costs that significantly exceed the average cost of comparable hospitals. This is done under the so-called section 223 reimbursement limits.

These five reimbursement rules account for two-thirds of this alleged cost shifting.

Now, why do we have these rules? Clearly, as I said earlier, we do not pay for unsponsored research because we pay for the sponsored research through NIH.

Second, we do not pay for nonmedicare bad debt because, in essence, that would be cost shifting from the private sector onto the Federal medicare program.

Senator KENNEDY. Do you have the figures for each of these categories?

Dr. RUBIN. Yes, sir. We could submit those for the record, if you would like.

[Information referred to follows:]

ADDITIONAL MATERIAL SUBMITTED BY DR. RUBIN

The Health Insurance Association of America (HIAA) has identified thirteen ways that Medicare allegedly "shifts" costs to private payors of hospital bills. Following is a list of five of the most important "shifts" from a fiscal standpoint, along with the proportion of the total "cost shift" attributable to that particular reimbursement rule. The proportions were calculated by the HHS Office of Planning and Evaluation.

- o Medicare has not reimbursed hospitals for the bad debts of non-Medicare patients (although it has paid for the bad debts of Medicare patients). This accounts for about 37 percent of the alleged "cost shift."
- o Medicare has not paid for hospital malpractice premiums that are not attributable to the malpractice claims experience of the Medicare population. (About 12 percent of the "cost shift").
- o Medicare has not paid for unsponsored medical research. (About 3 percent of the "cost shift").
- o Medicare has not paid for patient use of TVs and telephones. (About 3 percent of the "cost shift").
- o Medicare has not reimbursed the costs of hospitals significantly exceeding the average cost of comparable hospitals (223 limits). (About 12 percent of the "cost shift").

In our view, these have been readily defensible reimbursement policies:

- Medicare should not pay for costs generated by non-Medicare patients. This refusal does not represent cost shifting by Medicare but rather Medicare's refusal to have private costs shifted onto the health care program for the elderly and disabled.
- Medicare should not pay for unsponsored research; the Federal government pays its fair share of the nation's research through the $4 billion budget of NIH.
- Medicare should not pay for TVs and telephones because they are not medically necessary.
- Medicare should not pay for the costs of hospitals which are significantly more expensive than their competitors.

I would also emphasize that these specific reimbursement rules will become moot as we phase-in Medicare's prospective payment system. Under prospective payment, hospitals will, for the first time, have strong incentives to economize, rather than spending more and more, while shifting any unreimbursed excess to private payors.

Finally, I would note that private payors may well get a "wind-fall" benefit from Medicare's switch to prospective payment. If prospective payment causes hospitals to improve their efficiency, as we expect it will, private payors will also pay less for hospital care.

Senator Kennedy. Generally——

Dr. Rubin. The medicare reimbursement rules that I have just talked about represent about two-thirds of the alleged cost shifting. The exact magnitude of this cost shift, as I am sure you are aware, differs in the eye of the beholder, but it is alleged to be somewhere between $4 and $7 billion.

Senator Kennedy. Why don't you continue down the——

Dr. Rubin. We can go on, if you would like.

Senator Kennedy. Yes, well, where is the bad debt being paid at the present time? Who is supposed to pick that up?

Dr. Rubin. Well, we pay for——

Senator Kennedy. That is charity care.

Dr. Rubin. We pay for 100 percent of the medicare bad debt right now—that is, the bad debt that results when medicare patients cannot pay their deductibles and coinsurance for hospital care. The issue is who pays for the rest of the bad debt and whether it is the role of the Federal Government under medicare to pay for nonmedicare bad debt. The statutes say that we cannot do that, and we abide by the statutes.

Senator Kennedy. I see. Therefore, if you are very poor and you end up in a hospital and you are outside of these particular definitions, it is just tough going?

Dr. Rubin. Not at all.

Senator Kennedy. Does the administration believe that we ought to do something about that? Say you are just living within that particular category—that is what the statute says——

Dr. Rubin. Senator, we have been discussing medicare. As you well know, there is another program that deals with the people who are very poor, and that is medicaid. That is a Federal-State program that operates under a different set of statutes and reimbursement rules. I do not believe that there is any evidence that those people who are medicaid beneficiaries are not being given the care that they have requested at hospitals.

Senator Kennedy. I would like to ask just one more thing.

What evidence do you have that, under the DRG proposal, they are not just going to collect more from the private sector?

Dr. Rubin. Senator, there is no requirement that the private sector continue to be passive payers of bills. You will also recall that under Public Law 98-21, which contains the medicare prospective payment provision, if the citizens of a State believe that they want to come together, as they have in Massachusetts, to establish an all-payers ratesetting system, the Secretary of HHS may permit the State to incorporate medicare into the prospective payment system for all payers.

Senator Kennedy. Do you like the all payers?

Dr. Rubin. Do I like the all payers?

Senator Kennedy. The State all payers.

Dr. Rubin. No, absolutely not.

Senator Kennedy. I see. [Laughter.]

Dr. Rubin. Indeed, I think there is even evidence that some of the participants in the all payers under chapter 372 in the Commonwealth are having second thoughts.

The **Chairman.** I leave for 1 minute and Senator Kennedy takes advantage of my 5-minute rule.

Dr. RUBIN. That was my fault. I extended my response.

The CHAIRMAN. Senator Nickles.

Senator NICKLES. Dr. Rubin, I have a couple questions.

Do you have the figure on total expenditures, private and public, for 1982? Are those available yet?

Dr. RUBIN. National health expenditures in 1982, if my memory is right, were about $321.4 billion. That is an estimate; the final 1982 figures are not yet available.

Senator NICKLES. How much of that was public, Federal and State?

Dr. RUBIN. Roughly, 40 percent public, 60 percent private.

Senator NICKLES. Has that relationship increased over the past—as the percentage of public, of the total health expense, has that increased percentagewise year by year or remained fairly constant, or do you know? Do you have it?

Dr. RUBIN. The Federal share has increased over the last several years. We should be able to give you the precise numbers.

Senator NICKLES. I have a chart that goes up to 1981. I did not have the 1982.

Dr. RUBIN. In terms of national health expenditures for 1981, 42.7 percent public, 57.3 percent private, and that is contrasted to, say, 1965 when public expenditures were about 26 percent of the total.

Senator NICKLES. Do you have it for 1982?

Dr. RUBIN. For 1982? The 1982 figures aren't available yet.

Senator NICKLES. When you have those, I would appreciate your submitting those to our office and also for the record.

Dr. RUBIN. Fine.

[The tables referred to follow:]

Table I. National Health Expenditures, 1965-1982:
Amount and Per Capita Amount by Source of Funds, and Percent of the Gross National Product

		National Health Expenditures									
		Total			Private Funds			Public Funds			
	G.N.P. (billions)	Amount (billions)	Per capita*	Percent of GNP	Amount (billions)	Per capita*	Percent of total	Amount (billions)	Per capita*	Percent of total
1982...	$3,059.3	$322.4	$1,365	10.5%	$185.6	$786	57.6	$136.8	$579	42.4%
1981...	2,937.7	286.6	1,225	9.8	164.4	703	57.4	122.2	522	42.6
1980...	2,633.1	249.0	1,075	9.5	143.6	620	57.7	105.4	455	42.3
1979...	2,417.8	215.0	938	8.9	124.4	543	57.9	90.6	395	42.1
1978...	2,163.9	189.3	836	8.8	109.8	485	58.0	79.5	351	42.0
1977...	1,918.3	169.2	755	8.8	99.1	442	58.6	70.1	313	41.4
1976...	1,718.0	149.7	674	8.7	86.7	391	57.9	62.9	284	42.1
1975...	1,549.2	132.7	604	8.6	76.5	348	57.7	56.2	255	42.3
1974...	1,434.2	116.4	535	8.1	69.3	318	59.5	47.1	216	40.5
1973...	1,326.4	103.2	478	7.8	63.9	296	61.9	39.3	182	38.1
1972...	1,185.9	93.5	438	7.9	58.1	272	62.1	35.4	166	37.9
1971...	1,077.6	83.3	394	7.7	51.6	244	62.0	31.7	150	38.0
1970...	992.7	74.7	358	7.5	46.9	225	62.8	27.8	133	37.2
1969...	944.0	65.6	318	7.0	40.7	197	62.0	24.9	121	38.0
1968...	873.4	58.2	285	6.7	36.1	176	62.0	22.1	108	38.0
1967...	799.6	51.3	254	6.4	32.3	160	63.0	19.0	94	37.0
1966...	756.0	46.1	230	6.1	32.5	163	70.6	13.6	68	29.4
1965...	691.0	41.7	211	6.0	31.0	156	74.1	10.8	55	25.9

* Based on July 1 population estimates, which include the resident U.S. population and that of the outlying territories, plus Federal military and civilian employees and their dependents overseas.

Table II. National Health Expenditures in 1982, by Type of Expenditure and Source of Funds
(Billions of Dollars)

Type of Expenditure	Total	Private						Public		
		Total	Consumer			Other 1/		Total	Federal	State and Local
			Total	Patient	Insurance					
Total	$322.4	$185.6	$174.7	$90.4	$84.2	$10.9		$136.8	$93.2	$43.7
Health services and supplies	308.3	179.5	174.7	90.4	84.2	4.8		128.7	87.5	41.2
Personal health care	286.9	171.2	167.0	90.4	76.6	4.2		115.7	83.7	32.0
Hospital care	135.5	63.5	61.3	16.4	44.9	2.2		72.0	54.6	17.4
Physicians' services	61.8	44.8	44.7	23.1	21.7	*		17.0	13.4	3.6
Dentists' services	19.5	18.7	18.7	13.4	5.2	---		.8	.4	.4
Other professional services	7.1	4.9	4.9	3.6	1.3	.1		2.2	1.7	.5
Drugs and medical sundries	22.4	20.4	20.4	17.6	2.8	---		1.9	.9	1.0
Eyeglasses and appliances	5.7	4.8	4.8	4.4	.4	---		.8	.7	.1
Nursing-home care	27.3	12.3	12.2	11.9	.2	.2		15.0	7.9	7.1
Other health services	7.6	1.7	---	---	---	1.7		5.9	4.0	1.9
Program administration and net cost of insurance	12.7	8.3	7.7	---	7.7	.6		4.4	2.4	2.0
Government public health activities	8.6	---	---	---	---	---		8.6	1.4	7.3
Research, and construction of medical facilities	14.1	6.0	---	---	---	6.0		8.1	5.7	2.4
Research 2/	5.9	.3	---	---	---	.3		5.6	5.0	.5
Construction	8.2	5.7	---	---	---	5.7		2.5	.7	1.9

* Less than $100 million. 1/ Spending by philanthropic organizations, industrial in-plant health services, and construction financed privately. 2/ Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research," but are included in the expenditure class in which the product falls.

Table III. Sources of Funds for Personal Health Care Expenditures in 1982
Amounts and Percentage Distribution

Source of Payment	Total	Hos-pital Care	Physic-ians' Svcs.	Dent-ists' Svcs.	Other Prof. Svcs.	Medical Non-durables	Medical Durables	Nursing home Care	Other Personal Health
					AMOUNTS (BILLIONS)				
Total	$286.9	$135.5	$61.8	$19.5	$7.1	$22.4	$5.7	$27.3	$7.6
Direct patient payments	90.4	16.4	23.1	13.4	3.6	17.6	4.4	11.9	---
Third-party payments	196.4	119.2	38.7	6.0	3.5	4.7	1.2	15.4	7.6
Private health insurance	76.6	44.9	21.7	5.2	1.3	2.8	.4	.2	---
Philanthropy and industrial in-plant	4.2	2.2	*	---	.1	---	---	.2	1.7
Government	115.7	72.0	17.0	.8	2.2	1.9	.8	15.0	5.9
Federal	83.7	54.6	13.4	.4	1.7	.9	.7	7.9	4.0
Medicare 1/	50.9	36.3	11.4	---	1.3	---	.6	.5	.8
Medicaid 2/	16.9	6.2	1.5	.3	.4	.9	---	6.9	.8
Other	15.9	12.1	.5	.1	---	---	.1	.5	2.5
State and local	32.0	17.4	3.6	.4	.5	1.0	.1	7.1	1.9
Medicaid 2/	15.5	5.6	1.4	.3	.3	.8	---	6.3	.7
Other	16.5	11.8	2.2	.1	.2	.2	.1	.8	1.2
Exhibit: total Medicaid	32.4	11.8	2.9	.6	.7	1.7	---	13.3	1.5
					PERCENTAGE DISTRIBUTION				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Direct patient payments	31.5	12.1	37.3	69.0	50.6	78.8	78.2	43.6	---
Third-party payments	68.5	87.9	62.7	31.0	49.4	21.2	21.8	56.4	100.0
Private health insurance	26.7	33.2	35.1	26.9	17.7	12.5	6.9	.9	---
Philanthropy and industrial in-plant	1.5	1.6	.1	---	.9	---	---	.6	22.4
Government	40.3	53.1	27.6	4.0	30.7	8.7	15.0	54.9	77.6
Federal	29.2	40.3	21.7	2.1	23.7	4.2	13.1	28.8	52.9
Medicare 1/	17.7	26.8	18.5	---	17.9	---	11.3	1.7	9.9
Medicaid 2/	5.9	4.5	2.5	1.7	5.2	3.9	---	25.3	10.0
Other	5.5	8.9	.8	.4	.7	.2	1.8	1.8	33.0
State and local	11.1	12.8	5.8	1.9	7.0	4.5	1.9	26.1	24.7
Medicaid 2/	5.4	4.1	2.2	1.6	4.5	3.6	---	23.2	9.2
Other	5.7	8.7	3.6	.3	2.5	.9	1.9	2.9	15.5
Exhibit: total Medicaid	11.3	8.7	4.7	3.3	9.7	7.5	---	48.5	19.2

* Less than $100 million. 1/ Represents total expenditures from trust funds for benefits. 2/ Includes funds paid into Medicare trust funds by States under "buy-in" agreements to cover premiums for public assistance recipients and for persons who are medically indigent.

Senator NICKLES. I have a couple of other questions.

On the private percent—and I think you mentioned what, 50-some percent, 57 percent?

Dr. RUBIN. Fifty-seven.

Senator NICKLES. On the private, here's an employer that is out buying insurance. He finds this escalating to an enormous degree. I know that I have seen it rise in enormous fashions, and so many private employers have gone to what I would say is more of a cost sharing, larger deductibles where that employer would be picking up a larger and larger deductible, maybe on a cost sharing with his employee and 100-percent cost thereafter. There has been, I would say, some fairly good reception, trying to eliminate maybe the very low cost, routine-type expense, so that would be taken care of either by the employer or the employee in combination, but for the larger expense to be handled by the private sector.

You are kind of trying to move in that same philosophy, as I would see it, with some cost sharing on the lower end but with catastrophic coverage on the upper end; is that correct?

Dr. RUBIN. That is correct; yes, sir.

Senator NICKLES. I would commend you for it. I think that is a step in the right direction and would help to some degree.

With regard to Senator Kennedy's question, you said in medicare, medicare reimburses 100 percent of medicare bad debts?

Dr. RUBIN. Yes, sir.

Senator NICKLES. Therefore, if you had a person over the age of 65, if he goes into the hospital and cannot pay the deductible, eventually medicare would pick that deductible up?

Dr. RUBIN. That is correct.

Senator NICKLES. That is correct?

Dr. RUBIN. Yes, sir.

Senator NICKLES. That is the biggest bulk of it.

Then in medicare, what happens? Does it vary on a State-to-State basis on—I mean medicaid? If you have a deductible there that is not picked up or if you have some expense that is not picked up, is that split between Federal and State or is that pushed over into the private or the balance for the hospitals, or whatever, to pick that up?

Dr. RUBIN. In terms of medicaid bad debt, the costs are split based on the percentage of Federal financial participation, which varies from 50 to 78 percent, depending on the State.

Senator NICKLES. Would the Federal Government be picking up as much as 78 percent?

Dr. RUBIN. That is correct.

Senator NICKLES. Therefore, that split would be shared by Federal and State, but still that decuctible amount or that amount that was owed, whether it be on medicare or medicaid, if a person was not picking it up, would still be borne either by the Federal Government or Federal and State governments?

Dr. RUBIN. Right.

Senator NICKLES. Thank you very much.

The CHAIRMAN. Senator Metzenbaum.

Senator METZENBAUM. Dr. Rubin, part of the thrust of the Secretary's statement was that where you have increased efficiency and more utilization concentrated in a particular hospital or with a particular doctor, that is, fewer hospitals and physicians, each providing a larger volume of service, that you will have achieved some economies and, therefore, bring down the costs.

As she made that statement, I was thinking about the hospitals as well as some doctors who have CAT scanners. I was thinking of the microsurgeons. I was thinking of the kidney dialysis program. I was thinking of podiatrists who do a thousand times more business than they used to do, and that is a hyperbole, but that is good enough for the moment.

I cannot think of any instance where the doctors who were doing more heart surgery, for example, brought their rates down. They considered themselves greater experts, and so they raised their rates. I do not know of any instances in which costs have come down. Based upon normal procedures, competition and the free enterprise system, you would think that would occur, but it just does not follow in this case. I am wondering what evidence you have for that statement.

Dr. RUBIN. Let me make a clear distinction. The Secretary's statement talked about costs, and you talked about charges. I think that is a very important distinction to make.

There is no question that the marginal cost of doing additional open heart surgery is lower if you do more operations. Under the prospective payment system, there would be an incentive on the part of the hospital to maximize the number of, say, open heart surgery cases they do once they hit a certain level or critical mass.

There is abundant evidence to suggest that the larger the volume of open heart surgery that a particular surgeon does, the lower the morbidity and the mortality among his or her patients. By concentrating—say, open heart surgery—in a particular hospital, not only does the hospital experience lower costs percase, but the quality of patient care improves as the hospital team, if you will, becomes more proficient in doing it.

In terms of the other example that you used, as a nephrologist, I am somewhat familiar with the kidney dialysis program since it used to support my family prior to this job. I can tell you that if one looks at the cost—not the charges but the cost—of doing dialysis over time, that as the equipment has become more technically sophisticated, the cost per treatment has actually come down, particularly when you look at a base where the rate has not been changed since 1972 when the law was first passed. Indeed, the Federal Government, just I guess 10 days ago, put out new regulations for kidney dialysis that cut the rates even further. I think this is probably one of the few examples where over an 11-year period the rates recognized by the Federal Government have dropped for a procedure from an average of $138 to an average of about $130.

Senator METZENBAUM. Is there any logical reason to have a means test with respect to the availability of nephrology treatment?

Dr. RUBIN. I was unaware that there was a means test.

Senator METZENBAUM. I am asking whether or not there should be one. I know people who are extremely wealthy whose dialysis is totally free, and they, themselves, are amazed.

Dr. Rubin. Well, Senator, the renal disease program comes under the rubric of medicare, and medicare, as you know, is not means tested.

Senator Metzenbaum. It goes beyond the rubric of medicare, does it not, Doctor?

Dr. Rubin. No, sir.

Senator Metzenbaum. Can you not be on medicare and still get the free dialysis?

Dr. Rubin. No. Anybody that has end-stage renal disease qualifies for medicare.

Senator Metzenbaum. They can be under 65, can they not?

Dr. Rubin. Absolutely. The same would be true if you were disabled.

There are three ways you can be eligible for medicare. You can be disabled. You can have end-stage renal disease, or you can be over 65.

Senator Metzenbaum. Let me just ask you one final question on my time.

In February the GAO found that the Health Care Financing Administration was reluctant to exclude from medicare reimbursement, physicians who had been found to be habitual overutilizers. Query: Has HHS done anything about this problem, to carry out the suggestions of the GAO?

Dr. Rubin. The HCFA experts are caucusing back there, but I honestly do not know.

Senator Metzenbaum. My understanding is that you have not. Perhaps my question will prompt some further inquiry on your part, so that you might do something about it and maybe in that manner cut down on costs where the providers are involved rather than where the patients must pay more.

Dr. Rubin. I would certainly agree with that; yes, sir.

Senator Metzenbaum. Thank you, Doctor.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Metzenbaum.

Senator Denton.

Senator Denton. Dr. Rubin, I would like to pursue one line which Senator Metzenbaum brought up. I unsuccessfully tried to get a means test for free Government jobs training, knowing that there were some professional students who, if they could go around and do that, or older people who, just for the heck of it wanted to participate, could be eligible even if they were extremely wealthy. Why should this be permitted to happen?

He has raised a question about a means test for medicare. I do not see any lack of compassion——

Senator Metzenbaum. I raised the possibility of a means test for kidney dialysis, not for medicare across the board.

Senator Denton. Sir?

Senator Metzenbaum. I was not speaking of medicare across the board, just kidney dialysis.

Senator Denton. Oh, I see. OK.

I do not see the lack of compassion involved in the motivation to look into the question of a means test because it seems to me that those who are able to pay a portion of their cost are robbing those who are not and causing part of the escalation in health costs.

Is the answer to the majority who oppose a means test and who overcame me on the jobs training issue—is the proper answer that it costs more to conduct a means test? What I usually heard was you did not want to hurt the feelings of someone by asking them how much money they made or something like that. It did not impress me, but it did prevail in debate.

Why don't we have means tests for such matters when we are trying to deal with the poor or when we are not?

Dr. **Rubin**. Senator, I think the position of the administration is clear: the President said last October that he did not at this point in time favor a means test for medicare. That was reiterated not only by Secretary Schweiker, but has been reiterated since by Secretary Heckler.

I would imagine that the Advisory Council on Social Security, which is examining the long-term financial future of medicare, would look at this issue. We await their report.

Senator **Denton**. You say you imagine that one of the——

Dr. **Rubin**. I honestly do not know. As an independent commission of the Department, they are setting their own agenda. I honestly do not know whether this is one of the items on their agenda or not.

Senator **Denton**. Well, would you please find out? Are you qualified to find out whether they are going to do that or should I ask——

Dr. **Rubin**. I think we could ask the Commission to respond to your request, yes.

[Commission has responded to Senator Denton.]

Senator **Denton**. I would appreciate that, sir.

I promised someone, when I was running for office—a young woman who is not that poor, and I will not tell her name but she weighs about 70 pounds. She had multiple operations as an infant—I mean like 92 of them. She finally—she is a very beautiful little person—became engaged to a healthy male who made a modicum of money. She could not get married because her family health insurance covered her, and for a long period of time her fiance's would not have been able to do so.

I worked for about 1½ years and fixed it up so that the fiance's insurance was proper, and so forth.

What I am getting at is the gap in catastrophic health insurance which occurs between those categories which come under the poor label and the elderly label. What about the folks that are neither poor nor elderly? I am not saying this is a Federal Government question to answer, but how do you feel? What way do we have of getting at that other than a private plan which is prohibitively expensive?

Dr. **Rubin**. There are two responses to your story, Senator.

No. 1, if I remember your witness list correctly, you are going to have a representative of the private insurance companies later on this morning—maybe this afternoon. What you need to ask him about is the exclusion from coverage of prior conditions, which is really what precluded her from getting coverage.

The second issue has to do with the structure of insurance. As the Secretary mentioned in her opening statement, what we are seeing is a move away from first dollar comprehensive insurance at the front end with virtually nothing at the back end—which gets to your issue—to more and more companies going to some front-end cost sharing but a much more financially sound program with catastrophic insurance at the back end. Those types of policies would deal with the catastrophic issue for the vast majority of Americans who are covered by employment-based health insurance, roughly 160 to 175 million Americans.

The Chairman. Senator Quayle.

Senator QUAYLE. Dr. Rubin, I wonder if you would just make an assumption that we would have the most aggressive cost-containment approach as possible. Where would we be in the latter part of the 1980's, 1990, on medicare? Is there any way to get at the problem of medicare through cost containment and to save the trust fund? I am talking about the medicare health insurance trust fund.

Dr. RUBIN. We have already taken steps that will likely assure the trust fund's solvency through the 1980's. The most serious problems will occur in the 1990's CBO projects a cumulative trust fund deficit of somewhere in the neighborhood of $300–$400 billion by 1995.

I think we can close some of the trust fund deficit through aggressive cost control—for example, through the prospective payment mechanism. As important as these steps, are however, they are not enough to solve medicare's problems, which are in part problems of demographics. The demographics are such that, because of the incredible success we have made in this country in both the practice of medicine and biomedical research, longevity keeps increasing and the quality of the life for the elderly continues to increase. Yet that can mean increased medicare costs.

We think the basic medicare contract and what it is that we are covering need to be carefully examined. As the Secretary pointed out in response to Senator Hatch's question, the alternatives are all unappealing. What we need to do is to put together some mix of programs, perhaps increasing the payroll tax, perhaps dealing to some extent with benefits in order to put together a fiscally responsible package.

Senator QUAYLE. Under the most pessimistic set of statistics, how long do we have before the insolvency or bankruptcy will occur—worst case scenario?

Dr. RUBIN. The worst case scenario is about 1988.

Senator QUAYLE. And the best case scenario?

Dr. RUBIN. The best case scenario, with the Congress passing all of the things that the President recommended, is 1991.

Senator QUAYLE. So we have until 1991 and we are going to face insolvency or bankruptcy unless we do something on a comprehensive basis, which would be either look at the benefits, look at access, or just raise taxes. Is that correct?

Dr. RUBIN. Yes.

Senator QUAYLE. Secretary Heckler, in testimony, talked about the success that Du Pont had in offering employees two programs. How many programs does the Federal Government offer its employees?

Dr. RUBIN. The Federal employee health benefits program has dozens nationwide. They publish a book about that thick. I think that in previous meetings of this committee then Senator

Schweiker went through a fairly interesting anecdote trying to figure out what his health insurance was. I remember several other members of the committee expressed concern about the way those programs were presented.

Senator QUAYLE. Do you have any analysis of the results in cost containment to the Federal employees in the health insurance as a result of the way that the Federal Government runs its health insurance program by giving a number of options to the employees?

Dr. RUBIN. Senator, as you probably are aware, Donald Devine, Director of the Office of Personnel Management, has come up with a way to restructure that program in a way that would be consistent with the principles that are articulated in the President's health incentives reform program; namely, to give each employee a fixed amount.

Senator QUAYLE. Let me interrupt you. My time is up and I have to finish the questions.

The point is—what I am trying to extract from you, and maybe you can submit it for the record—is giving employees all these options, my question is, and I do not know, is this a good thing to do——

Dr. RUBIN. Yes.

Senator QUAYLE [continuing]. As far as holding down costs? If that's the case, I would say submit the analysis of the Federal Government; program and all the options that you offer the employees, and I would imagine that you would probably in your conclusion that the health care costs have not been controlled at all. As a matter of fact, it has gone up. I do not know what the findings would be. I do not think we have had a great deal of success compared to the private sector. I think it is certainly an area for research and to try to come to some conclusion. I certainly do not have any conclusions, but I think it is an open question on how far we go.

I am not talking about 2; I am looking at 20 or 30 or how many you say we have. I just want to know how good an idea—she pointed out in her testimony of one success, but that was with two programs——

Dr. RUBIN. May I give you an example?

Senator QUAYLE [continuing]. Two programs, and I look at the Federal program that we have, and we are supposed to sort of set the tone for these things, and I am not so sure what kind of a track record we have on controlling health care costs.

Dr. RUBIN. We have a good track record. Let me give you two numbers.

We recently took a look at exactly the question you just raised. While you can make all kinds of comments about the intelligence of workers in the Department of Health and Human Services, I would say that they are probably average compared to workers across the country.

During the May 1982 open season, the average employee health insurance contribution for HHS employees in Washington and Baltimore fill 10 percent, without a significant change in their benefits. This 10-percent figure was calculated by comparing the 1982 premium of the plan actually chosen with the 1982 premium of the employee's previous plan. Indeed in the last several open enrollment periods across the Government, there has been a significant move toward lower premiums without a commensurate loss of benefits. We will supply you with those numbers.

Senator QUAYLE. I would like to see that because I think that is a very crucial point.

[The data referred to is summarized in the HHS' response to Senator Quayle's written questions on FEHBP.]

Senator QUAYLE. If that is true and we can see a success, I believe we ought to amplify on that and try to set the tone for a direction that we ought to pursue.

Dr. RUBIN. OK.

Senator QUAYLE. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Quayle.

Thank you, Dr. Rubin. We will submit the rest of the questions.

Senator KENNEDY. I have just one observation. I would just hope that perhaps my associates might take an opportunity to read through the report to Congress, "Hospital Prospective Payment for Medicare," because in the report it does show the success of the different States that have moved ahead with some cost containment program. The difference between the States that do have cost containment and those that do not is about 3 percent in health care costs. That is billions of dollars. Extrapolating in the out years, it is dramatic. You are talking tens of billions of dollars.

When the Senator asked the question: We either are going to have to reduce benefits or we are going to have to increase the taxes and reduce access," I do think that there are alternatives. One of them is a cost containment program.

Now the States have taken some action. I would just remind the Senators that on that chart up there, when you had similar rates of increase in the Consumer Price Index and in the hospital index were the times that the Congress had under consideration a cost containment program. When we lost that legislation, the costs just went up and escalated dramatically. This is the chart of the different States.

Senator QUAYLE. But my question, and at least his response was, that you could not achieve a solvency by the early part of 1990 through the most optimistic, aggressive cost containment program, not the administration's, just the most aggressive cost containment program; that you are not going to be able to solve it solely by cost containment, which is going to get us back to some very unpleasant political decisions that you and I do not want to make.

Senator KENNEDY. That is right.

Senator QUAYLE. At sometime we are probably going to have to.

Senator KENNEDY. I would say that the Senator is probably right, but I would also say is that we are spending the money in the health care system but we are spending it irrationally. We are spending all the bucks that you can possibly imagine, more than we are spending on national security and national defense, but it is an irrational allocation of resources that I think has grown over the period of time. Unless we are prepared to look at the whole concept of systems, and perhaps we are not at this time——

Senator QUAYLE. I certainly think that we ought to look at it, and I am sure Chairman Hatch will take us in that direction to look at it. However, I think people ought to be sensitized to what we are facing in the early 1990's in this medicare problem.

The CHAIRMAN. These comments have been interesting.

I am going to let you respond to this, Dr. Rubin, but let me just point out I think there are alternatives. Utah, for instance, has one of the lowest hospital rates in the Nation and it has a market approach. I think we could learn perhaps even from my humble State of Utah.

Dr. Rubin, go ahead.

Dr. RUBIN. I would just like to respond to the number that Senator Kennedy read. I thank him for using our statistics, but he did not point out that States with mandatory rate-setting systems, that do not encompass all payors—that is, States that have partial State ratesetting systems covering only some payors—have achieved about the same amount of cost control as the States with all-payers systems. From 1976 to 1980, the rates of increase in per capita hospital expenditures in the some payors and, in the all payors States were almost identical.

The CHAIRMAN. In spite of cost containment?

Dr. RUBIN. In spite of—that is correct. I do not think that the answer necessarily has to be an all-payers system. It is true that the numbers that the Senator cites are in our report; these others may or may not.

I think the prospective payment system for medicare is an example of the Federal Government leading by example. We hope other payers, both State and private payers, will follow suit and undertake their own cost-containment efforts. They can achieve the same kinds of cost control without excessive regulation.

The CHAIRMAN. Under the approach that Mrs. Heckler gave us today, that the administration has attained, when do you expect to see any dramatic change over past history?

Dr. RUBIN. As you know, medicare prospective payment was set up to be budget neutral relative to TEFRA for this upcoming year. We should begin to see changes from prospective payment—changes in behavior and changes in reimbursement patterns—in fiscal 1985.

The CHAIRMAN. Thank you.

Dr. Rubin, thank you for coming. We appreciate the effort that you have put in. We will submit questions to you, if you would answer those as quickly as possible.

Dr. RUBIN. Thank you.

The CHAIRMAN. Thank you, sir.

The CHAIRMAN. Our second panel brings before us two noted specialists in health care economics. We hope to gain from them differing perspectives on current trends which exacerbate costs in the health care marketplace.

First is Dr. Jack Meyer, resident fellow in economics and director of the Center for Health Policy at the American Enterprise Institute.

Second is Dr. Carl Schramm, director of the Center for Hospital Finance & Management at Johns Hopkins Medical Institute.

Dr. Meyer, we will begin with you.

We are going to put all statements of all witnesses in the record as though fully delivered. Therefore, I would like you to limit yourselves to 5 minutes.

STATEMENT OF DR. JACK A. MEYER, RESIDENT FELLOW IN ECONOMICS AND DIRECTOR OF THE CENTER FOR HEALTH POLICY, AMERICAN ENTERPRISE INSTITUTE, COLUMBUS, OHIO

Dr. **Meyer**. I will honor that, Mr. Chairman, and just briefly summarize the highlights of my prepared statement.

I want to start by raising something which Senator Denton was getting at in his question and that is the issue of fairness, both in the large and small perspective.

In the large perspective, the issue arises as to who pays for the necessary austerity that we have in this country. I would submit that while the burden may be necessary, we have laid a disproportionate share of that burden, on working poor and near poor families and all low-income households. The further we go with this inequity the more the needed austerity will be jeopardized and a return to the highly inflationary policies of the past will be encouraged.

In the smaller perspective, we can raise the question of fairness in health care financing. If one looks at the size of what the Federal Government is doing, it gives you a much better perspective on proposals for reform.

If you start by realizing that the value of Federal tax subsidies, estimated at about $31 billion in 1983, is 1½ times as large as the entire Federal contribution to medicaid, you begin to realize that the Federal Government is subsidizing many people, including those of our best-paid workers, even more heavily than the low-income people.

The medicare program which, of course, goes to all income people, as I think it should, is about $60 billion in the coming fiscal year. Yet, as we have been cutting back in domestic spending, where have we been cutting back? In medicaid, the program for low-income people, it is very similar to the other budget activities where I think we have gone too far in some areas and not for enough in others.

Now we have a new set of proposals before us for beginning to nick the tax expenditures and beginning to change medicare. People scream, "this is draconian this is unfair." Well, if you look at it in isolation, it could seem to be unfair, but I raise the question—who is willing to contribute a little to this necessary belt tightening?

If high-paid workers scream when you want to tax maybe $100 or $150 of their benefits at the margin, workers who sometimes have $40,000 to $45,000 a year in wages and benefits, if the elderly scream when you want a nominal amount of cost sharing for hospitalization, even if that is used to purchase a catastrophic policy for them, is this really any different from the screams you hear every day from the farmers, the veterans, from business and from all interest groups who want to protect their subsidies?

If we are going to continue down a sensible economic path, we are going to have to begin to trim benefits going to all people, including programs in the Defense Department and benefits in our nonmeans-tested program, as well as effect needed reforms in our means-tested program.

I just do not think we can continue to cut say, a billion dollars in a program lie AFDC, which may be 15 percent of the program, and not cut a program at all that may be many times that large.

In reference to the chart presented here today showing soaring health costs, let us not think that the Federal Government was doing nothing during the time when those health care costs rose. We were laying one set of controls after another on the health care system, and look what it bought us. It isn't that we have been doing nothing. I think we need a new approach.

Controls have been tried.

In fact, I would like to point out that while price increases slowed down in the period of controls in the early 1970's, the quantity of services consumed and total outlays rolled along at double-digit levels. Price controls are not the answer.

I see 3 fundamental problems in the health care system. The first is as a lack of choice of plans for employees. Eighty-two percent of Americans in the workplace who buy group insurance have no choice of plans, according to an HHS-sponsored study. Another problem is open-ended Federal tax subsidies that give you more subsidies the higher your income is; and, finally, ironically, Government regulation itself, which I think has retarded innovation and been very counterproductive on the whole.

Therefore, I would like to recommend the following steps.

We need to place a ceiling on the chief open-ended tax subsidy—the exclusion from employee taxable income of employer contributions to health insurance. We need to build protection against expenses associated with catastrophic illness into medicare, combined with greater cost sharing for routine services——

Senator DENTON. Would you give the one about catastrophic, please, again, Dr. Meyer?

Dr. MEYER. Yes. I am suggesting building protection against expenses associated with catastrophic illness into Medicare. By that, I mean the fact that cost sharing starts after you have been in the hospital 60 days, except for the first day, and then it gets more serious after 90 days. We could end this exposure and finance that by some measure of front-end cost sharing. I favor converting medicare to a program of vouchers that could be used for any qualified plan, not just HMO's; continue further deregulation; and use existing antitrust laws to encourage fair competition among alternative health plans and scale our aid to the poor to their income.

Let me say that in response to a point made by Senator Quayle, I think that the DRG system and other elaborate controls, not to mention all-payers systems, are like putting a finger in the dike in the medicare program; my proposals may be, too, but I think they are more sensible.

All payers is a euphemism for systemwide price controls. Let's call it what it is.

However, my proposals will not contain the flood tide coming in medicare—we have those hard decisions facing us. We are going to have to either take a look at benefits or raise taxes. I think this is a symptom of a larger problem. We are an underfunded society, given the commitments we have made. If we do not touch defense and we do not touch a lot of these other major areas, and anything that smacks of a small tax increase is taken right off the board, then the alternatives will be things like means testing for medicare; it will be things like annihilating programs going to low-income people.

When you call proposals that I favor unfair or proposals that somebody else favors unfair, look what is happening around the country. States are cutting covered services under medicaid. They are desperate for ways to come up with funds. Reforms are being proposed—the kind that Dr. Schramm favors, the kind that I favor. People come up with arguments to blow them out of the water, so the States are cutting covered services—14 days of hospitalization, 10 days. How far are we willing to go with that?

Let me summarize by saying it seems to me we need a set of new incentives that are geared to the heart of the problem. The heart of the problem is a lack of choice and the presence of incentives in the system that reward cost generation, rewards profligacy, but do not reward innovation.

Therefore, we have to adopt these reforms and also trim benefits for those who can afford it. If that does not go far enough, we will have to raise taxes or bring our commitments in line with taxes.

Thank you.

The CHAIRMAN. Thank you, Dr. Meyer.

[The prepared statement of Dr. Meyer, along with responses to questions asked by Senator Hatch, follow:]

Prepared Statement

of

Jack A. Meyer
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American Enterprise Institute for Public Policy Research

before the

Committee on Labor and Human Resources
United States Senate

Washington, D.C.
May 19, 1983

*The views expressed in this testimony are those of the author and do not necessarily represent those of the American Enterprise Institute, a nonprofit research and educational institution that does not take positions on public policy issues.

Mr. Chairman: Thank you very much for the opportunity to appear before this committee. Health care reform should be built around the following principles: (1) benefit redesign that creates financial incentives for people to economize on the use of routine health services, while offering greater protection from the costs of serious illness and incentives for noninstitutional alternatives to care delivered in higher-cost institutional settings; (2) federal aid to low income people that increases with increasing need, and vice versa; (3) fixed dollar instead of open-ended federal subsidies to aid those unable to purchase adequate health insurance; and (4) increased choice of health plans for both employees and government beneficiaries. Incorporating these changes into government policy will require a major overhaul of federal programs.

These principles can be implemented through the following changes in government policy:

- place a ceiling on the chief open-ended tax subsidy for health care -- the tax-free status of employer contributions to employee health insurance;
- build protection against expenses associated with catastrophic illness into Medicare, combined with a greater measure of cost-sharing for routine services;
- convert Medicare to a program of premium subsidies to be used for Medicare coverage or any qualified alternative plan;

- continue the process of deregulation in areas such as certificate-of-need and flexibility for states to alter reimbursement policies under Medicaid;
- use existing antitrust laws to encourage fair competition among alternative health care plans and providers;
- convert Medicaid to a system of sliding scale premium subsidies in which the very poor would be fully subsidized.

In its new FY 1984 budget, the Reagan administration has endorsed several of these proposed steps. The administration has proposed a tax subsidy ceiling, Medicare benefit redesign, and a voucher system for Medicare. None of these steps will be immediately politically popular and the administration deserves credit for proposing steps that, finally, are addressing the causes of our problems of health care financing instead of the symptoms.

My concern is that the Reagan administration -- and Congress -- will remain the prisoners of past policies, particularly by becoming ensnared in the implementation of the Tax Equity and Fiscal Responsibility Act of 1982 (H.R. 4961) and the prospective payment plan embodied in the new 1983 Social Security legislation. The health care provisions of these two laws suggest that Congress has not yet confronted the real problems with our health care finance system. The three fundamental forces that have driven up the costs of health care are: (1) open-ended federal tax subsidies for the purchase of ever more comprehensive insurance which inflates the demand for health-care services; (2) a lack of choice in the purchase of health insurance for both employees and government beneficiaries; and (3) ironically, government regulation itself, which tends to confirm the status quo, protecting those who provide too much health care too expensively and impeding innovative efforts to lower costs.

In my view, only two of the many provisions relating to health care in recent federal legislation even begin to address these basic problems, and these two steps in the right direction need to be extended or modified significantly if they are to hold real promise of improving the efficiency of the system.

Prospective Payment

Prospectively-set rates or spending amounts may reverse some of the inherently cost-generating incentives associated with retrospective, cost-based reimbursement, but are subject to other problems. Many prospective systems retain few elements of "prospectivity" once they are implemented and end up being tied to the same allowable cost system that has characterized federal reimbursement policy for years. Also, prospective payments to providers may put some ex ante pressure on each provider to cut costs, but may not encourage true economies as much as they lead to service cutbacks. And prospective payment, per se, is just a better way, in theory, of financing insurance coverage in a world where there is either no choice between traditional health plans and other plans with altered incentive structures or a biased choice that favors the traditional plan and handicaps the innovators.

The federal government, after dragging its feet for years on developing a new reimbursement mechanism, is rushing headlong into a very complex payment system based on diagnostically-related groups (DRGs). Although this approach sounds promising, it is easier to describe a process of separating patients on the basis of diagnosis than to implement such a system. There is evidence that individual diagnostically-related groups will contain patients with widely differing needs (e.g., the severity of the condition may differ substantially), and such differences would be associated with widely-varying price tags. This will lead to a process of continuous refinements and appeals from hospitals that feel the system has not adequately controlled for their particular case mix. And it could encourage cream-skimming and penalize providers who treat a disproportionate share of complicated cases.

Furthermore, despite its complexity and detail, a DRG system is still, ironically, incomplete as a cost control mechanism. As long as hospital admissions are not brought into the loop, cost containment will prove elusive. As currently structured, the system encourages both more than one hospital admission for a medical problem that could be treated in one hospital spell and an upward "creep" in discharge diagnoses to increase revenues. These trends are particularly problematic in view of the evidence suggesting that rates of hospital admission are very important in explaining the cost advantage that pre-paid plans have over traditional health plans.

Hospital admission rates as well as the number and type of services performed are controlled by physicians, responding according to their training, their perception of patient expectations, and local practice patterns. The proposed DRG prospective payment system eliminates the perverse incentives of cost-based reimbursements, but it remains a highly indirect, tenuous way of getting at the main causes of hospital spending growth in excess of general inflation. In effect, it places the burden on hospital administrators to control physician decisions.

I am concerned that the new prospective payment program is viewed by the government as a first line of defense against the imminent crisis in Medicare financing. Simply stated, it is not up to the task. Even if the DRG system works as planned on the drawing board (an outcome that I consider highly uncertain, at best), it would be a flimsy barricade against the tidal wave of under-funded commitments rushing toward our shores. A recent report by the Congressional Budget Office highlights in stark terms the magnitude of expected deficits in Medicare funding under current law in the latter part of this decade and the 1990s. To meet this challenge will require at a minimum that we make major changes in the current cost-generating incentives in our health care system. We may also have to trim benefits for those who can best afford it. To the extent that such changes fall short of reconciling our commitments with available resources, we will have to augment available resources by either raising taxes or cutting other categories of spending.

Medicare Payments to HMOs

TEFRA modifies current law by authorizing prospective reimbursement under risk sharing contracts with competitive medical plans at 95 percent of the Adjusted Average Per Capita Cost (AAPCC). The new provision, in effect, would share savings associated with lower HMO costs between the federal government and Medicare enrollees who select an HMO.

Greater use of HMOs by the elderly may not do much to encourage overall health care cost containment: although HMOs have a cost edge at present, they may well have that edge because their members are younger and healthier than average. A system of medical vouchers for Medicare patients might do much more, by allowing a variety of new health plans — including case management or preferred provider organizations — to compete with HMOs and the traditional Medicare plan for taxpayers' dollars. (Congress considered, but dropped a proposal of this sort in 1981-1982.)

A Question of Fairness

This raises a general concern I have with the fairness of the austerity required to achieve sustainable economic growth in this country. The health care sector is a microcosm of a broader fairness problem. In health care we continue to dish out open-ended tax subsidies flowing largely to middle and upper income households at the same time as a significant number of our citizens fall between the cracks of public health care programs and the private health insurance market. The working poor are particularly victimized by cutbacks in government assistance to low-income households while the unemployed and those out of the labor force who are categorically ineligible for Medicaid are also vulnerable.

Capping our open-ended tax subsidies would yield significant savings that could be used to help those who can least afford the sacrifice required by continued belt tightening. Such a step would by no means finance coverage for all who are in need, but it would be a start.

At the moment we are on a collision course because we are trying to accomplish a huge defense buildup while holding down federal taxes. These trends, combined with a reluctance to make more than minor changes in many of our most costly social programs, lead to massive federal deficits. And, this policy combination places intense pressure on the remaining portion of the federal budget in order to contain deficits. If such pressure on social spending continues, it will jeopardize the basic nutrition, health and housing requirements of our most needy citizens.

We cannot avoid massive Federal deficits with a lot of rhetoric about welfare cheating or "fraud and abuse." The entire AFDC budget comprises less than 1 percent of federal spending. A cut of $1 or $2 billion in programs like AFDC, Food Stamps, SSI, or Medicaid produces significant hardship for low-income households, yet would hardly dent the projected deficits. In fact, such cuts could almost be lost in the rounding errors of the deficit totals. Instead of big changes in small programs, we need some changes in all programs. Massive deficits can only be averted if the entire budget is subjected to intense scrutiny. A concern with fairness requires us to bear down harder on non-means tested programs and ease up on programs geared to low-income families.

I surely do not wish to return to past policies of excessive stimulus, nor do I wish to "finance" automatically spiralling social spending through accelerating inflation, taxes, and a weakened defense capability. In order to maintain a credible, sustainable anti-inflation policy, however, it will be necessary to reassess the pace at which we continue to cut taxes or rebuild our defense posture. Holding down marginal tax rates -- a step that I favor -- will require a politically courageous effort to broaden our tax base. A more equitable and comprehensive approach to expenditure control is required, and to the extent that substantial deficits remain in the face of such control, measures must be taken to augment federal revenues. I believe that the latter step could be accomplished even as we preserve the limitation of effective marginal tax rates through the indexation plan scheduled under current law.

Responses to Questions Submitted
by the Committee on Labor and Human Resources
United States Senate

July 14, 1983

1. I believe that market-oriented approaches cover both public sector reforms using incentives rather than controls and private sector efforts. I favor this approach.

I am wary of simply relying on voluntary pledges to meet some target for cost deceleration while leaving intact the basic forces driving costs. Voluntary "campaigns" and promises leave me cold. But private sector actions to contain costs can be helpful, and we see growing evidence of benefit redesign, disease prevention programs, coalitions, the growth of alternative delivery and finance systems, etc., in the private sector.

It is important that these private sector reforms, along with offering people a choice of plans and rewarding cost-conscious choices, be fostered by public policy changes. A tax subsidy cap is key here, and is an excellent example of my point that public policy reforms and private initiatives go hand in hand. I believe that workers will demand more choice of plans when it is clear that beyond some point higher-cost plans will cost them something. It is no surprise that we now have so little choice when people are largely shielded from the extra cost of the highest cost plans.

I am very skeptical about regulation, which I think tends to hide costs and favor the traditional approaches to health care over innovative approaches.

2. This study has just been completed and sent to the committee. I am attaching an extra copy here. I am also attaching a press release that highlights the key findings of the study.

3. I believe that a better approach to Medicare involves the use of vouchers, adjusted for average area health costs, age, and perhaps one or two other factors. The voucher concept, as applied to health care programs, was proposed in Congressman Gephardt's bill (H.R. 850), and is designed to give low-income households access to the mainstream of medical care delivery. It could also be used for Medicare. It is important to design this approach so as to minimize adverse risk selection by providers or consumers seeking to control costs by enrolling only the healthiest people. Another concern is to set the level of the voucher (and update it for inflation) in such a way that recipients can purchase a comparable package of benefits as they receive under traditional government plans. There will also be a need to provide clarifying information materials specially designed to the needs of the target population.

In the private sector a corresponding approach can be achieved through a ceiling on the chief tax subsidy -- the exclusion of employer contributions to employee health insurance -- and by responsible, prudent-buyer approaches followed by firms and workers. In some cases this would involve individual company actions and in others collective or cooperative actions to use the buying power of private purchasers to exert pressure on sellers -- in this case hospitals -- to lower the cost of a given quality of services. This is preferable to government pressure on hospitals through stifling controls that subordinate quality to cost containment.

In summary, if the public sector, through vouchers and a more rational, fair system of cost-sharing, and the private sector, through encouraging preferred provider organizations, HMOs, IPAs, or other arrangements that hold the promise of a better cost/quality tradeoff, can act as prudent buyers, we can improve the situation. Both employers and the government can steer their employees and beneficiaries to lower-cost providers, which often involves more careful use of hospital facilities by physicians. I believe that such cost-conscious behavior can be induced through proper incentives -- it need not be mandated.

4. I believe that the rising number of physicians is generating competitive forces in the health care marketplace. The extent to which this occurs varies from region to region, in line with variations in supply-demand relationships.

I do not believe that the government should try to "fine-tune" subsidies to expected future balances or imbalances, which are always changing. Inasmuch as there is still a very high rate of return to a medical education, the government's main role, in my view, should be to assist in the provision of student loans, repayable at market rates of interest.

There are a growing number of instances of physician interest in new models of cost management, even where this entails an increase in provider risks. Primary care networks coupled with case management systems are being developed in many states to contain Medicaid cost increases. In Massachusetts and Michigan, groups of doctors are working with the state government to develop new programs.

There is also an increase in the proportion of physicians in group practices. It is difficult to ascertain with certainty the extent to which these trends are related to supply/demand relationships, but this would seem to be a relevant factor.

5. The most important factor is the faulty reimbursement system operating in Medicare during this period. The retrospective, cost-based or allowable-cost system fed cost increases by failing to distinguish among providers, i.e., by reimbursing high-cost or profligate providers on a like basis as more cost-conscious ones.

There was little choice of plan under Medicare. with less than 1 percent of Medicare eligibles enrolled in HMOs. The rise in hospitalization rates for the elderly resulted in part from this financing system, but also from technological breakthroughs. These factors combined to make increases in "intensity" a key factor in Medicare growth. The other key factor was the sharp general inflation during this period.

The CHAIRMAN. Dr. Schramm.

STATEMENT OF CARL J. SCHRAMM, PH.D., J.D., DIRECTOR, CENTER FOR HOSPITAL FINANCE AND MANAGEMENT, JOHNS HOPKINS MEDICAL INSTITUTE, BALTIMORE, MD.

Dr. SCHRAMM. Thank you, Mr. Chairman.

I think, to begin, it is important to point out a few general economic facts, and Senator Kennedy has already alluded to them in his opening remarks.

The rate of cost inflation in the hospital was extraordinary last year—historically, extraordinary with prices in hospitals going up three times the CPI. We experienced a great shift, a historically disproportionate shift, over the last 10 years in the real wealth of the percent of GNP going into the hospital and health industry; all this at a time when the general economic indicators indicated that we had less than 2-percent growth in real GNP.

Last year was the best year ever in the case of bottom line of our Nation's hospitals. All this took place at a time when the Congress for the third year in a row had to reduce titles 18 and 19. You began with the reconciliation bill in 1981. You carried on with TEFRA, and this year with the amendments to the Social Security Act. All this new wealth, all this new increase in price, and yet fewer people are covered and covered less well.

Part of the problem that creates this is, we have still to wrestle with the profound institutional difficulties in this marketplace. Hospitals continue to act in an inefficient way. There is no indication that they should behave elsewise. They are cost-based reimbursed. Insurance companies still continue to protect people from the real cost of their care. Hospitals are paid on a cost-plus basis. Physicians play both sides of the street. They are both purchasing agents buying on behalf of consumers and at the same time selling services to the same consumers.

All this happens with a great aura of professionalism attached to the marketplace, which creates a sense of ignorance and inability to get information on the part of consumers.

You have been asked repeatedly--and this morning we have seen another display of a petition to you to rely on marketplace solutions, go competitive. I would submit to you that the administration came to Washington committed to a procompetitive solution to the health care cost and the health care total price problem. Even as they argue for tax caps, the experiments with vouchers, increases in coinsurance, all on a competitive agenda, this administration has turned full scale to the biggest regulatory step, through TEFRA and through the Social Security Act amendments, that any administration has ever taken in Washington. Indeed, at the same time that they rail against rate setting in the regulated States, they have adopted as their institutional position, as the administration's position, all the lessons that have come from 6 and 7 years of State rate setting.

We now have prospective payment. That was engineered in Maryland in 1975.

Senator KENNEDY. Would you explain that? Maybe it is clear to everybody else. Can you just explain that point again?

Dr. SCHRAMM. Prospective payments, Senator?

Senator KENNEDY. No; just the last part about the change in the regulatory——

Dr. SCHRAMM. Essentially, Senator, the lessons that have come from the ratesetting experience—and I have included the evidence in two charts appended to my testimony—indicate that among all the various attempts that Dr. Meyer has indicated have been taken by the Federal Government since 1966 to reduce the rate of inflation, the only attempt that has statistical significance in reducing both the per capita growth of the industry and the rate of change in prices paid by consumers has been the experiment with mandatory rate setting at the State level. States have done this on their own. They did it in the face of great hostility from the Congress and from administrations throughout this experience.

Nevertheless, the prevailing experience has been that through a prospective-based system, all payers, in a system that pays on a per case base—that is the DRG system, which has also been adopted by the administration—all of those are lessons to have come only from State rate setting. Those lessons I think have been persuasive, notwithstanding the rhetorical opposition, basically because of the empirical underlying facts. They have done the job.

Now I would just like to close my comments by saying that I do not think that a total regulatory system is what, in fact, is going to solve this problem totally. We, in fact, do need to make people more price sensitive. We, in fact, do need to have hospitals operate more like business firms, being sensitive to marketplace indicators and marketplace signals.

What I do mean to say, if we get caught up in a discussion about rhetorical terms, competition versus regulation, we will miss the lessons of both sides.

In the competitive proposals—for example, vouchering systems—there has to be a very heavy hand of Government guidance; namely, regulation. Insurance, schemes of every kind have been regulated since 1910 when New York innovated insurance regulation.

On the other side, a regulatory approach, for example, in Maryland has set in place many of the same market signals one would hope to come from a competitive solution. Hospitals in our State are guaranteed under the rate system a full budget. If that hospital can deliver the same amount of care, controlled for the complexity of cases and controlled for the volume and adjusted for inflation, that hospital can keep savings—another innovation from rate setting that was adopted and made part of TEFRA.

I would submit basically that the issue that lies before us is really to search for the pragmatic and workable solution. That is what Americans demand. They do not want a rhetorical outcome or a commitment to rhetoric which in 5 years does not work.

We have—and I could not agree with Dr. Meyer more—a very fundamental problem before us. We are spending an awful lot of money in the hospital industry and in the health care system. Our commitment of real wealth grows every single year. By 1985 we will be spending 11 percent of Gross National Product under any projections on health care.

At the same time, there is marginal evidence that the population of the United States grows healthier. We must ask the question, are we getting our money's worth? As you well know, we are operating in times of great competition between social programs. Is it right for our society to commit to Star Wars-type hospitals when we are not attending to our defense strategy, when we are not reconstructing our roads, when we are not tending to our agricultural program?

I think basically we must put into the crucible of testing politically these tradeoffs between what health claims and what other public enterprise claims.

Thank you.

The CHAIRMAN. Thank you, Dr. Schramm.

[The prepared statement of Dr. Schramm follows:]

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WHAT ECONOMICS TELLS US ABOUT REFORMING THE LAW OF HOSPITAL FINANCING: TOWARD A MIXED STRATEGY

TESTIMONY BY

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BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
98TH CONGRESS, FIRST SESSION, MAY 19, 1983

MR. CHAIRMAN, IT IS A GREAT PRIVILEGE FOR ME TO HAVE BEEN INVITED TO SPEAK BEFORE THE COMMITTEE THIS MORNING ON A TOPIC OF THE UTMOST IMPORTANCE TO THE SENATE AT THE MOMENT, NAMELY, WHAT COURSE SHOULD THE CONGRESS TAKE IN DEVISING A NEW APPROACH TO THE REFORM OF HEALTH CARE FINANCING. THE OBSERVATIONS REGARDING THE STATE OF OUR NATION'S SYSTEM OF FINANCING ITS HEALTH CARE HARDLY NEED REPEATING. SUFFICE IT TO SAY THAT SOMETHING IS DYSFUNCTIONAL WHEN IN CALENDAR YEAR 1982 WE SAW A MARKED INCREASE IN THE AMOUNT OF REAL ECONOMIC WEALTH BEING COMMITTED TO THE HEALTH CARE SECTOR WHILE AT THE SAME TIME FEWER PERSONS WERE COVERED BY THE NATION'S MEDICAID PROGRAM THAN THE YEAR BEFORE, AND THAT THE COVERAGE OF THE PROGRAM WAS LESS EXTENSIVE. LIKEWISE, THE CONGRESS HAS RECENTLY PASSED MAJOR LEGISLATION DESIGNED TO REDUCE THE COST OF MEDICARE TO THE FEDERAL BUDGET.
THUS, GOVERNMENT HAS FOUND IT NECESSARY TO REDUCE ITS COMMITMENT TO THE ELDERLY AND THE POOR EVEN THOUGH THE REAL RESOURCES FLOWING FROM BOTH PUBLIC AND PRIVATE SOURCES INTO OUR NATION'S HEALTH CARE SECTOR HAVE CONTINUED TO GROW.

CALENDAR YEAR 1982 POINTED UP A RELATED ANOMALY WHICH MUST BE MENTIONED AS A PRELUDE TO MY COMMENTS. AT A TIME WHEN INCREASES IN PRICES IN GENERAL WERE IN A MARKED STATE OF DECLINE, PRICES IN THE HEALTH CARE SECTOR, AND HOSPITAL PRICES IN PARTICULAR, INCREASED AT THEIR HISTORIC RATES, AND OUTPACED THE C.P.I. FOR

ALL GOODS AND SERVICES BY A FACTOR OF THREE.

WHY IS IT THAT THE HEALTH CARE SECTOR DELIVERED LESS LAST YEAR WHILE IT CONSUMED MORE? WHY IS IT THAT IN THE FACE OF A RECESSION, WHILE OTHER SECTORS EXPERIENCED BOTH REDUCED REVENUES AND DECLINES IN THE RATE OF PRICE INFLATION, THAT HOSPITAL PRICES GREW SO RAPIDLY? WHY IS IT THAT AT A TIME WHEN THE CONGRESS, STATE LEGISLATURES, CORPORATE EXECUTIVES AND UNION LEADERS AGONIZED ABOUT HOW THEY WERE GOING TO PAY THE BILL FOR THE RESPECTIVE POPULATIONS THEY MUST INSURE, THAT THE NATION'S HOSPITALS EXPERIENCED ONE OF THEIR MOST PROFITABLE YEARS ON RECORD? THESE ARE CRITICAL QUESTIONS WHICH THE COMMITTEE MUST CONSIDER AS IT SETS OUT TO EXAMINE THE PROBLEM OF WHAT SHOULD BE DONE TO REFORM THE FINANCING OF OUR NATION'S HEALTH CARE DELIVERY SYSTEM.

I WOULD RESPECTFULLY SUGGEST THAT RELIANCE ON ECONOMIC THEORY IS CRITICAL, BUT THAT THE LESSONS IT OFFERS WHICH ARE PERTINENT TO UNDERSTANDING THE HOSPITAL INDUSTRY ARE LIMITED. INDEED, ABOUT TEN YEARS AGO, MANY ECONOMISTS VENTURED INTO STUDIES OF THE ECONOMIC BEHAVIOR OF THE HOSPITAL INDUSTRY AND VIRTUALLY ALL OF THEM HAVE DESERTED THE AREA. ONE REASON IS THAT THE CLASSICAL RULES WHICH GOVERN OTHER INSTITUTIONS AND OTHER EXCHANGES DO NOT APPLY IN THE EXPECTED WAY IN THE HOSPITAL INDUSTRY.

THE TRANSACTION BETWEEN THE CONSUMER/PATIENT AND THE HEALTH CARE SYSTEM DOES NOT LEND ITSELF EASILY TO ECONOMIC ANALYSIS. THE SERVICE SOUGHT IS, BY ITS VERY NATURE, SPECIAL. IT IS NOT HOMOGENEOUS IN THAT EACH PATIENT EXPECTS AND IS GIVEN AN INDIVIDUALLY TAILORED SET OF SERVICES. THE PURCHASE OF HEALTH CARE IS A

DISCRETE AND DISCONTINUOUS EVENT FOR MOST PEOPLE, THUS INFORMATION IS DIFFICULT TO ACQUIRE, AND ONCE ACQUIRED, OFTEN OUTDATED BY THE RAPID DEVELOPMENT OF TECHNOLOGY. THE PATIENT IS, TO A VERY LARGE EXTENT, INSULATED FROM THE COSTS OF RECEIVING MEDICAL ATTENTION BY THE PRESENCE OF INSURANCE. INSURANCE PROTECTS THE CONSUMER FROM INTERNALIZING COSTS, AND, AS EVERYONE KNOWS, MEDICINE IS TREATED MORE LIKE A FREE GOOD. OUR PRIVATE AND PUBLIC POLICY HAS CONSISTENTLY ENCOURAGED THIS RESULT EVER SINCE WORLD WAR II BY ESTABLISHING RATHER COMPREHENSIVE HEALTH INSURANCE AS AN INCIDENT OF EMPLOYMENT FOR WORKING AMERICANS AND THEIR FAMILIES VERY BROAD COVERAGE FOR THE ELDERLY UNDER MEDICARE, AND UNTIL RECENTLY, RATHER EXTENSIVE CARE FOR THE POOR UNDER MEDICAID. THE PRESENCE OF INSURANCE, MORE THAN ANY OTHER FORCE, NEGATES MARKET ANALYSIS OF THE HEALTH CARE TRANSACTION. CONSUMERS TURN OVER CONTROL OF THEIR USE OF RESOURCES TO PHYSICIANS. THE ROLE OF THE PHYSICIAN AS PURCHASING CONSULTANT IS ENFORCED BY THE NECESSARY DELEGATION OF DECISION MAKING IN LIGHT OF THE COMPLEX SKILL AND KNOWLEDGE MEDICINE REQUIRED OF ITS PROFESSIONALS. THE OPERATING PRICIPLES OF INSURANCE REIMBURSEMENT ARE WIDELY REGARDED AS ESTABLISHING POWERFUL INCENTIVES TO USE MORE RESOURCES, ESPECIALLY HOSPITAL-RELATED RESOURCES, IN THE TREATMENT OF PATIENTS THAN MIGHT BE CLINICALLY NECESSARY.

THESE RATHER GRAND DEPARTURES FROM A MARKET-ORIENTED DISTRIBUTIONAL SYSTEM ARE COMPOUNDED IN THE CASE OF THE HOSPITAL. THE TYPICAL AMERICAN HOSPITAL WAS ESTABLISHED ON EXPLICITLY COUNTER-MARKET PRINCIPLES. AS A VOLUNTARY PROVIDER OF CARE, ADVANCING A SERVICE ETHIC, THE HOSPITAL WAS ORGANIZED TO GIVE

CARE EXPRESSLY ON THE GROUNDS OF NEED AND NOT ABILITY TO PAY.

AS THE UNIT COST OF A HOSPITAL ENCOUNTER GREW, AND AS HOSPITAL GRADUALLY LOOKED TO PATIENTS TO HELP SUPPORT THE COST OF THEIR CARE, A PHENOMENON NOT WIDELY OBSERVED BEFORE THE 1940'S, PERSONAL HEALTH INSURANCE PLANS, OFTEN VOLUNTARY IN THEIR OWN ORGANIZATION (E.G., BLUE CROSS), WERE ESTABLISHED TO PROTECT AGAINST ECONOMIC RISK. AS GOVERNMENT ASSUMED THE ROLE OF PAYING FOR THE CARE OF THE ELDERLY POOR IN 1965, A CHAPTER HAD CLOSED ON THE HOSPITAL AS A CHARITABLE INSTITUTION WITH REGARD TO ITS SOURCES OF FUNDING BUT NOT WITH REGARD TO ITS ORGANIZATION AND SELF-IDENTITY. THE TYPICAL HOSPITAL IS STILL A NON-PROFIT, VOLUNTARY INSTITUTION WITH A SPECIAL MISSION IN THE SOCIETY TO WHICH IT IS DEDICATED.

IN RECENT YEARS, ENTREPRENEURIAL HOSPITALS HAVE EMERGED AS A SIGNIFICANT NEW APPROACH TO HOSPITAL ORGANIZATION. THIS DEVELOPMENT IS LINKED LARGELY WITH THE ABILITY OF NEWER, MORE MANAGERIALLY FLEXIBLE INSITUTIONS TO MAKE A PROFIT THROUGH OPERATING EFFICIENCIES, CAREFUL SELECTION OF RISKS (AVOIDING COMMUNITIES WITH LOWER-INCOME AND HIGHER AGED POPULATIONS), AND BY BEING ABLE TO ACQUIRE TECHNOLOGY AND NEW PLANT THROUGH LOWER CAPITALIZATION COSTS BECAUSE OF SHAREHOLDERS' EQUITY CONTRIBUTIONS. (MOST VOLUNTARY HOSPITALS HAVE BEEN FORCED TO USE DEBT-FINANCING, USUALLY AT ABOVE MARKET RATES, FOR NEW EQUIPMENT AND CONSTRUCTION.)

NOTWITHSTANDING THE SUCCESS OF THE PROPRIETARY HOSPITAL, WITH REGARD TO ITS PRICING POLICY IT FACES THE SAME NON-MARKET ABERRATIONS FACED BY THE VOLUNTARY HOSPITAL. LIKEWISE, THE HOSPITAL HAS LITTLE ABILITY TO SET AND ACHIEVE TARGET PRICE

LEVELS, IN THE CASE OF THE FOR-PROFITS, OR OPERATING SURPLUSES IN THE CASE OF THE VOLUNTARIES. HOSPITALS DO NOT SET PRICES IN THE SAME WAY THAT THE FIRM DOES, IN RESPONSE TO SUPPLY AND DEMAND. NOR DO THEY CONTROL THEIR LEVEL OF PRODUCTION. IN THE FIRST INSTANCE PRICE IS NOT DETERMINED BY THE INTERPLAY OF HOSPITALS WITH INDIVIDUAL PATIENTS. FOR THE MOST PART, THE PATIENT DOES NOT STAND IN PRIVITY WITH THE HOSPITAL; RATHER, HIS INSURANCE CARRIER DOES, AND IT IS THE CARRIER THAT BARGAINS WITH THE HOSPITAL AS TO WHAT RATE WILL PREVAIL OVER A GIVEN PERIOD. SIMILARLY, THE HOSPITAL CAN ONLY AFFECT LEVELS OF PRODUCTION OR COSTS INCURRED IN THE PRODUCTION PROCESS IN THE LOOSEST WAY. RESOURCE UTILIZATION IN THE HOSPITAL IS IN THE HANDS OF PHSYCIANS, FROM THE DECISION TO ADMIT A PATIENT AND INVOLVE THE HOSPITAL IN THE FIRST PLACE, TO WHAT DRUGS, NURSING CARE, SUPPLIES, ETC., THE PATIENT WILL USE, UNTIL THE MOMENT OF DISCHARGE. THE PHYSICIAN DOES ALL THIS WITHOUT ANY EMPLOYMENT RELATIONSHIP WITH THE HOSPITAL. THE HOSPITAL GRANTS PRIVILEGES TO THE PHSYCIAN TO PRACTICE THERE, BUT DOES NOT EXTRACT ANY POWER TO INFLUENCE THE PHSYCIANS' PATTERN OF PRACTICE OR RESOURCE USE. WHILE ECONOMIC SYMBIOSIS EXISTS, IT IS NOT SUFFICIENT TO ENGAGE THE PHYSICIAN IN THE ECONOMIC DECISION MAKING OF THE HOSPITAL NOR DOES IT CONTEMPLATE THE HOSPITAL INFLUENCING THE ECONOMIC DECISION MAKING OF THE PHYSICIAN.

A CURSORY DESCRIPTION OF THE ANOMALIES OF THE MARKET FORCES IN THE HEALTH CARE MARKET WOULD NOT BE COMPLETE WITHOUT PASSING MENTION OF THE IMPORTANCE OF PHYCIANS OPERATING AS A PROFESSIONAL GROUP, WITH ALL THE SOCIAL IMPORTANCE ATTACHED TO SUCH IDENTITY.

ONE INCIDENT OF THE STRONG PROFESSIONAL IDENTITY OF PHYSICIANS IS THAT PATIENTS TEND NOT TO QUESTION THE DOCTOR'S JUDGMENT IN MATTERS RELATED EVEN TO THEIR OWN POCKETBOOKS. OF COURSE, PHYSICIANS, AS PROFESSIONALS, OPERATE TO PRESERVE THEIR ROLE AS INTERMEDIARIES BECAUSE IT HAS OBVIOUS ECONOMIC BENEFITS. THE LITERATURE ON THE EFFECTIVENESS OF THE PHYSICIAN CARTEL IS EXTENSIVE AND ITS POWER IS EVIDENT DAILY IN THE POLITICAL PROCESS THROUGH, AMONG OTHER THINGS, ITS AGGRESSIVE USE OF THE POLITICAL ACTION COMMITTEE DEVICE.

WITH ALL THESE FORCES AT WORK, FOR THE MOST PART INTENDED TO SUBVERT THE NORMAL OPERATION OF A CLASSICAL PRICE-CLEARED MARKET, IT IS DIFFICULT TO IMAGINE THAT MARKET-ORIENTED SOLUTIONS SUCH AS VOUCHERS AND TAX CAPS WILL HAVE ANY EFFECT. THE ARCHITECTS OF THESE OPTIONS HAVE DESIGNED THEM AS A SECONDARY FORCE, I.E., THAT BY ENCOURAGING PEOPLE TO PURCHASE INSURANCE MORE WISELY AND BY FORCING THE INDIVIDUAL TO BEAR SOME ECONOMIC RISK FOR HIS CONSUMER BEHAVIOR, HOSPITALS AND DOCTORS WILL BE COMPELLED TO OPERATE MORE EFFICIENTLY AS THEY ENCOUNTER MARKET-LIKE PRESSURE FOR LOWER PRICES. THE FUNDAMENTAL PROBLEM WITH ALL SECONDARY APPROACHES TO A PROBLEM IS THAT SOMETHING CAN GO WRONG IN THE APPLICATION. ONE OF THE OBVIOUS FLAWS, DEMONSTRATED RATHER CLEARLY WITH THE MEDICARE CO-INSURANCE REQUIREMENT, IS THAT PEOPLE WILL DEMAND NEW FORMS OF INSURANCE TO INSULATE THEMSELVES FROM UNDESIRED RISK. UNDER ANY VOUCHER PLAN, FOR EXAMPLE, THOSE WHO CAN WILL ENTER THE MARKET AND PURCHASE INSURANCE FOR THAT PART OF THEIR RISK WHICH IS NOT COVERED BY GOVERNMENT INSURANCE OR IS LIMITED BY STATUTE IN THE PRIMARY INSURANCE POLICY. THE

CONGRESS CAN NOT OUTLAW THE DEVELOPMENT OF SUPPLEMENTAL INSURANCE. NOR CAN THE CONGRESS PRETEND THAT A VOUCHER PLAN OR TAX CAPS WILL NOT FALL WITH DISPROPORTIONATE IMPACT ON THOSE WHO ARE LESS ABLE TO AFFORD CARE IN THE FIRST PLACE. THOSE WHO WILL BE AT RISK IN ANY SUCH PLAN ARE THOSE WITH FEWER RESOURCES TO BEGIN WITH, PRECISELY THE POPULATION FOR WHICH GOVERNMENT SHOULD HAVE PRIMARY RESPONSIBILITY. THUS, THE NOTION OF A MARKET-TYPE SOLUTION MUST BE EXAMINED IN LIGHT OF OUR SHARED VALUE OF REDISTTRIBUTION.

BUT, FROM THE ANALYTIC PERSPECTIVE, THE REAL PROBLEM WITH THE COMPETITIVE APPROACHES IS THAT THEY DO NOT DEAL DIRECTLY WITH THE FORCES CAUSING THE PROBLEM THEY ARE OFFERED TO SOLVE IN THE FIRST PLACE, NAMELY HEALTH CARE COST INFLATION. THE MERE ESTABLISHMENT OF VOUCHERS, FOR EXAMPLE, DOES NOT UPSET THE INSTITUTIONAL OBSTACLES TO THE DEVELOPMENT AND WORKING OF A FREE MARKET IN HEALTH CARE. NO OTHER EXCHANGE OF SERVICES IS MORE EASILY CHARACTERIZED AS FROUHGT WITH INSTITUTIONAL INTERESTS THAN THE HEALTH CARE EXCHANGE. HOSPITALS, DRUG COMPANIES, INSURANCE CARRIERS, PHYSICIANS, HOSPITAL EMPLOYEES, TECHNOLOGY MANUFACTURERS ALL HAVE AN INTEREST IN THE CONTINUATION OF THE CURRENT RELATIONSHIPS AND BALANCES OF POWER. TO PUT IN PLACE A VOUCHER ARRANGEMENT BETWEEN CONSUMERS AND INSURORS, IS TO BELIEVE THAT THE MARKET OF TOMORROW CAN BE ESTABLISHED BY CHANGING THE RELATIONSHIP BETWEEN THE CONSUMER AND HIS OR HER INSUROR AND THEN WAITING FOR THE FALLOUT, WHICH IS EXPECTED TO BE GREATER PRICE RESPONSIVENESS ON THE PART OF ALL PROVIDERS.

EVENTUALLY, THEN, WE MUST COME TO THE QUESTION OF WHAT

IS TO BE DONE, OR IN THE CONTEXT OF THIS HEARING, WHAT WILL WORK TO EFFECTIVELY REDUCE HOSPITAL COST INFLATION AND THE OVERALL COST OF OUR HEALTH CARE ENTERPRISE. I WOULD SUGGEST THAT EXPERIENCE TO DATE SUGGESTS THAT A MIXED REGULATORY AND COMPETITIVE STRATEGY IS WHAT IS CALLED FOR. IN THE SHORT RUN, WITH TRADITIONAL MARKET SIGNALS SO DISTINCTLY MISSING, IT IS IMPERATIVE THAT GOVERNMENT STEP IN TO ESTABLISH THE BUILDING BLOCKS OF WHAT EVENTUALLY CAN BE A MARKET-LIKE EXCHANGE. IN THE LONG RUN, MUCH WILL BE GAINED BY MAKING MARKET SIGNALS, ESPECIALLY PRICE, MORE IMPORTANT TO CONSUMERS IN THE DECISION AS TO WHETHER TO ENTER THE MARKET FOR HEALTH SERVICES AND HOW MUCH JUDGMENT TO EXERT AT THE APPROPRIATE TIME IN TERMS OF WHAT CARE SHOULD BE PURCHASED. PURSUIT OF A MIXED STRATEGY IS NOT UNREALISTIC, INDEED, IT IS THE COURSE WE HAVE ALREADY CHOSEN. MOREOVER, IT IS THE PRAGMATIC COURSE WHICH PERMITS EXPERIMENTATION AND THE DEVELOPMENT OF NEW IDEAS IN AN AREA IN WHICH IT IS EVIDENT THAT NO SINGLE SOLUTION IS SUITED TO THE TASK OR IS POLITICALLY FEASIBLE.

WHAT EXPERIENCE AM I REFERRING TO? FIRST OF ALL, THE EXPERIENCE IN MARYLAND AND THE OTHER STATES WITH MANDATORY RATE-SETTING IS MOST INSTRUCTIVE. RATE-SETTING, OF ALL THE PUBLIC AND PRIVATE INITIATIVES TAKEN OVER THE LAST DECADE, IS THE ONLY EFFORT TO YIELD SIGNIFICANT REDUCTIONS IN BOTH THE INCREASE IN THE COST OF A STAY IN THE HOSPITAL AND IN THE COST PER CAPITA FOR AN EXTENDED PERIOD OF TIME. I HAVE INCLUDED IN MY TESTIMONY AS EXHIBITS 1 AND 2 CHARTS SHOWING THE STATE EXPERIENCE UNDER RATE-SETTING. IT IS IMPRESSIVE AND IT HAS INFLUENCED THE ADMINISTRATION AND THE CONGRESS. INDEED, THE SOCIAL SECURITY AMENDMENTS ENACTED

EARLIER THIS SPRING WERE INFLUENCED SIGNIFICANTLY BY THE EXPERIENCE WITH RATE-SETTING. IT IS IN STATES SUCH AS MARYLAND THAT DRG- OR CASE-BASED REIMBURSEMENT WAS FIRST USED TO PAY HOSPITALS AS EARLY AS SEVEN YEARS AGO. IT WAS IN RATE-SETTING JURISDICTIONS THAT THE NOTION OF PROSPECTIVE PAYMENT WAS ENGINEERED. MARYLAND WAS THE FIRST STATE, IN 1977, TO RELY ON A SINGLE PRICE FOR ALL PAYERS, AN INNOVATION WHICH THE CONGRESS MUST CONSIDER IN THE FUTURE. AND, FROM THE PERSPECTIVE OF THE DEVELOPMENT OF A MIXED STATEGY, IT WAS IN MARYLAND THAT THE IDEA OF INCENTIVE-BASED REGULATION WAS FIRST DEVELOPED. WE CONCEIVED OF THE IDEA OF LETTING HOSPITALS SHARE IN SAVINGS WHICH THEY WERE ABLE TO ACHIEVE UNDER OUR GUARANTEED INPATIENT REVENUE SYSTEM, AN IDEA WHICH WAS INCORPORATED INTO TEFRA. IT IS COMMENDABLE THAT THE SOCIAL SECURITY AMENDMENTS OFFER A SIGNIFICANT STIMULUS TO STATES TO EMBARK ON NEW EXPERIMENTS WITH RATE-SETTING. MUCH CAN STILL BE LEARNED BY LETTING STATES EXPERIMENT UNDER THE INFLATION TARGETS ESTABLISHED IN WASHINGTON, AND WE SHOULD ENCOURAGE STATE-BASED SOLUTIONS WHICH ARE BOTH REGULATORY AND MARKET-ORIENTED IN NATURE.

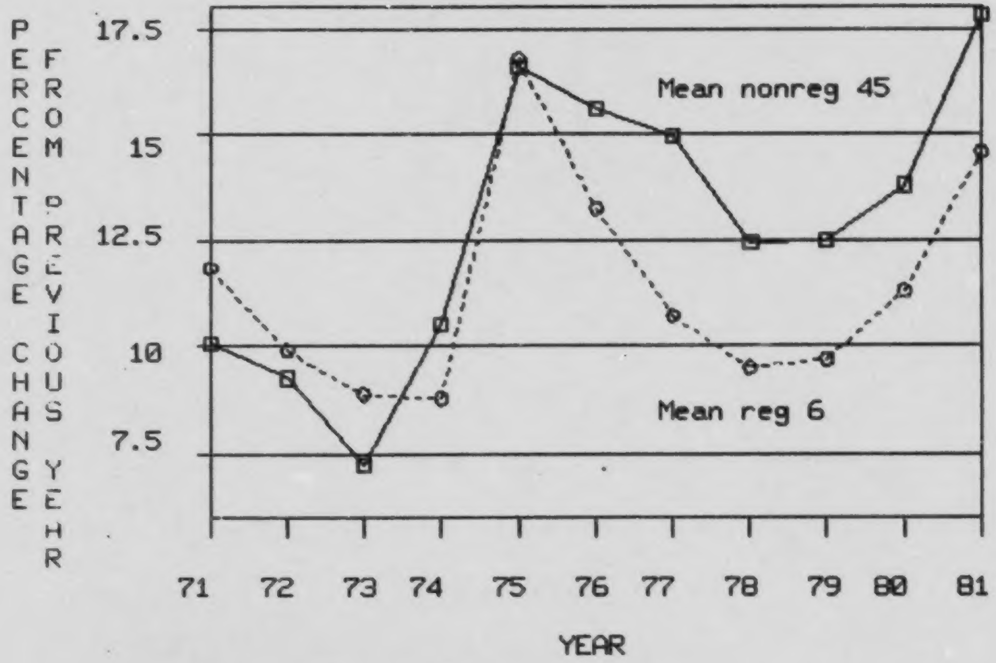
BUT JUST AS REGULATORY INNOVATIONS LIKE RATE-SETTING FORESHADOW THE DEVELOPMENT OF MARKET SIGNALS, YOU MUST REALIZE THAT MANY OF THE SO-CALLED COMPETITIVE APPROACHES ARE HIGHLY DEPENDENT ON REGULATORY ACTIVITY. FOR EXAMPLE, IN ORDER FOR A VOUCHER SYSTEM TO WORK ADEQUATELY, GOVERNMENT MUST POLICE THE INSURANCE MARKET WHICH DEVELOPS UNDER THE LAW SO AS TO PROTECT CONSUMERS FROM ABUSES BY BOTH INSURORS AND EMPLOYERS, AND, UNDER SOME PLANS, TO LIMIT THE EXTENT OF THE SECONDARY MARKET FOR INSURANCE.

I PERSONALLY AM PLEASED TO SEE, WITHIN THE LAST SIX MONTHS, THE DEVELOPMENT OF A SIGNIFICANT EMPLOYER PRESENCE IN MANY COMMUNITIES QUESTIONING THE CURRENT LEVELS OF HOSPITAL PRICES. BUT, IN REALITY, WHAT EMPLOYERS ARE SEEKING IS JOINT BARGAINING POWER TO E THE PRICE WHICH HOSPITALS WILL TAKE BY LIMITING THE ABILITY OF THE HOSPITAL TO BARGAIN FOR DIFFERENT PRICES WITH DIFFERENT PAYERS, SUCCESSIVELY INCREASING THE PRICE WITH EACH BARGAIN. SUCH AN ARRANGEMENT CAN BE EASILY CHARACTERIZED AS PRIVATE REGULATION OF PRICES ON A COMMUNITY-BY-COMMUNITY BASIS. LIKEWISE, THE DEVELOPMENT OF CONTRACTUAL BARGAINING WITH PROVIDERS IN CALIFORNIA FOR THE TREATMENT OF THE STATE'S MEDICAID BENEFICIARIES IS EASILY CHARACTERIZED AS BOTH A TRIUMPH OF COMPETITION, AS THE STATE APPEARS TO BE BEHAVING LIKE A PRUDENT BUYER EXERCISING ITS BARGAINING POWER, AND OF REGULATION, SINCE THE STATE, BECAUSE OF ITS COERCIVE POWER AS A PUBLIC ACTOR IS REALLY SETTING PRICES UNILATERALLY FOR THE PROVISION OF MEDICAL SERVICES.

IN CLOSING, I WOULD LIKE TO POINT OUT THAT THE JOB THAT LIES BEFORE THE CONGRESS IS THE SOLVING OF THE COST INFLATION PROBLEM WHICH BESETS THE NATION, NOT THE CHOSING OF ONE IDEOLOGY OVER ANOTHER. PRAGMATIC ADOPTION OF WHAT WILL WORK IS THE BEST STEP. WHILE MARKET-ORIENTED SOLUTIONS ARE ALWAYS DESIRABLE IN OUR FORM OF GOVERNMENT AND IN OUR ECONOMY, THE EXTRAORDINARILY DYSFUNCTIONAL NATURE OF THE HEALTH CARE EXCHANGE MAKES THE IMMEDIATE ADOPTION OF MARKET-LIKE APPROACHES ILL-ADVISED, TO SAY THE LEAST. GOVERNMENT MUST, IN THE SHORT RUN, GIVE GUIDANCE TO THE SYSTEM OF HEALTH CARE WHICH DEVELOPS. GOVERNMENT MUST HELP TO ESTABLISH A CULTURE OF EFFICIENCY IN OUR HOSPITALS AND TO ENCOURAGE MORE RATIONAL MANAGEMENT OF OUR HEALTH CARE ENTERPRISE. IN THE SHORT RUN, THIS CAN ONLY BE ACCOMPLISHED BY REGULATION, A POLICY WHICH WE HAVE TURNED TO BEFORE AND WHICH HAS WORKED, AND WHICH WILL SERVE US WELL IN THE SOLUTION OF THIS PROBLEM.

EXHIBIT 1

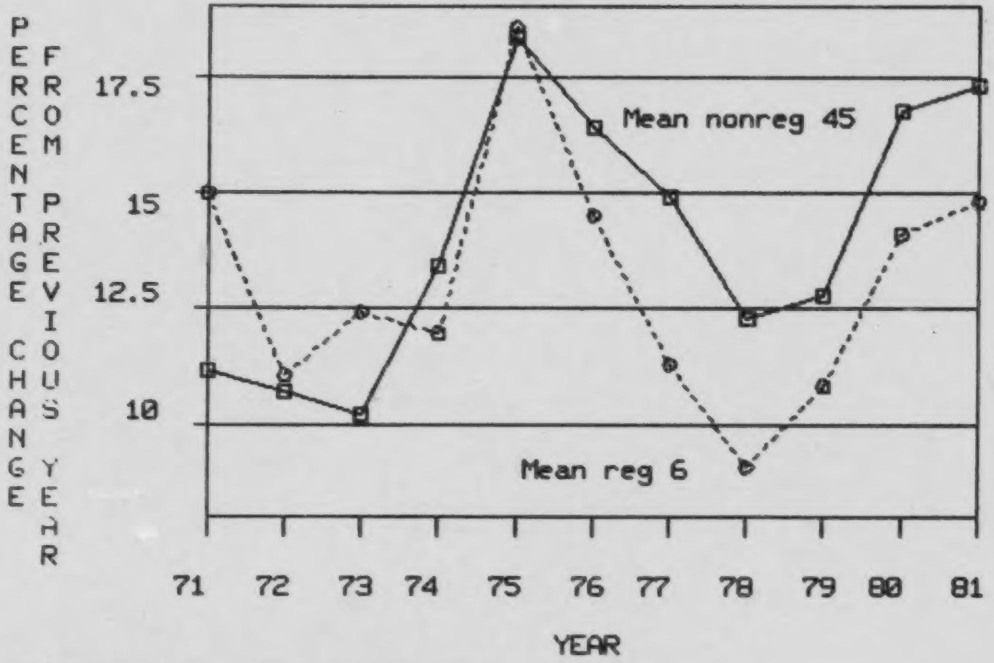
PERCENTAGE CHANGE IN EXPENSE PER ADMISSION (ADJUSTED)



THE CENTER FOR HOSPITAL FINANCE & MANAGEMENT
The Johns Hopkins Medical Institutions

EXHIBIT 2

PERCENTAGE CHANGE IN EXPENSE PER CAPITA



The **Chairman**. Dr. Meyer, I am one who agrees that our present system of payment for health care has interfered with the operation of natural market forces and I think has contributed to the dramatic increase in rise of health care costs. Since there are three basic approaches to altering the health care market—basically, regulation, market-oriented approaches, and voluntary private efforts—which of these do you view as the most effective or the proper direction we should go?

Dr. **Meyer**. Well, I favor a combination of the last two. I think they are related. It seems to me if you——

The **Chairman**. You mean market-oriented and voluntary private approaches?

Dr. **Meyer**. That is right.

By voluntary, I do not mean something like the voluntary effort that was described and caricatured earlier. I am not talking about promises, but the kind of actual private sector responses around the country which can be nourished by the appropriate Federal incentives.

I would respond to your question by saying that I think a starting point is for the Federal Government to send the right signals for a change, by establishing rational subsidies. We do need subsidies, but make them rational; we should reward cost-consciousness, and do this in a fair way.

I think that this will then encourage demand for a choice of plans by private sector employees. Dr. Schramm has mentioned a number of State rate-setting efforts—there are also, and I think you referred to these, a number of other kinds of what I would call more market-like experiments going on in the States under waivers from the Federal Government. These are underway in your State of Utah, Mr. Chairman, in California, in Arizona, in Kentucky, in Michigan, and other States.

I think that we need a pluralistic approach to this problem, but I think that the Federal Government can nourish this instead of forcing these efforts to swim upstream.

The **Chairman**. Thank you. I would point out that, although rate controls—and we have had some comments about rate controls—have been enacted in about six States, only New York has sufficiently or significantly contained costs. In New York, arbitrary controls have postponed needed capital spending. Finally, the ultimate regulation of supply in Great Britain and Canada I think has resulted in producing such long waiting lists for health services that many citizens even die before they reach the top of the list. Therefore, I am concerned about further regulation or further controls, which I do not think work, anyway, and produce an inferior medical system.

You may disagree with me.

Dr. Schramm, should health care reforms take place at the Federal level or should States and/or localities be allowed, maybe indeed encouraged, to develop their own approaches to restraining health care costs?

Dr. **Schramm**. Senator, I have felt for a long time that the States, as I said before, have swum against the Federal Government until only recently in attempting their own experiments and demonstrations. Maryland, for example, set out upon this program in 1971, as did the other regulated States within the 3-year period 1971 to 1974.

I think that much of the problem with inflation and total costs varies immensely from State to State. In many respects the hospital industry is still a State and local enterprise, and State solutions are commendable and I think should be stimulated by the Federal Government. I think recent legislation, particularly the social security amendments, have gone in that direction.

I would say one other thing, though, Senator. Looking at the data on all the regulated States, only the State of Washington has produced a nonstatistically significant record and specifically with the question of New York. Much is raised about the question of hospital capital in New York, and it is focused specifically around the question of the closing of hospitals in the State of New York over the past 5 years.

However, the untold side of that story is that over the past decade the State of New York has lost over a million people. Hospitals have shut in New York, but also grammar schools and colleges and high schools have shut in the State of New York, as well as libraries and museums. Somehow the hospital industry in New York has brought to the world a message that that particular industry should be preserved, even when there are a million fewer people to be taken care of, even when the finances and industrial base for the State of New York are woefully behind the growth of the rest of the country—that somehow those hospitals should have been preserved at all costs. I would suspect that that is just not a rational outcome and merits very careful examination.

The CHAIRMAN. My time is up. Senator Kennedy.

Senator KENNEDY. I have just some observations.

Dr. Meyer, I was interested in your analysis of the administration proposal and certainly would agree that it appears that too much is being taken from the poor and working class and too little from the well-to-do. My concern about the tax cap is that it will dampen down the utilization of both primary and preventive care and will hurt the low-income and older workers and do very little about the hospital costs.

Dr. MEYER. Well, that is an understandable concern. I think that it can be addressed.

First of all, the tax cap that the administration has proposed is $175 a month on a family policy. You can get pretty good health insurance for $175 a month. If you want to continue, as auto workers do, having their companies contribute about $300 a month, you can still do that, it would not be prohibited, but what we are saying to those auto workers or steelworkers is, if you opt for the Cadillac of health insurance, in effect, that is fine but you are going to have to pay a little bit for it. I think that is important. I think it is fair.

I would urge the administration to make and honor a commitment to use the proceeds of that kind of revenue for unemployed workers, for people who are working at the minimum wage or thereabouts, and for folks totally out of the labor force who fall between the cracks of Federal programs and private sector insurance.

I think if you view it that way it is of less concern. I think there are studies to indicate—and one that comes to mind is by Gail Wilenski at the National Center for Health Services Research—that people are pretty rational about their selection; that they do not give up the vital things that they would need such as hospitalization, and I think the results recent responses by Federal employees to open season indicate the same sorts of things.

Finally, let me just add that it is very possible that in the face of a tax cap when there are two plans that offer essentially the same benefits, but one of them which is more expensive than the other, the lower cost plan would then be in the interest of the consumer to select. Everybody wins from that outcome, and benefits are not sacrificed.

Senator **Kennedy**. Well, in the non-Cadillac insurance proposal—let's say in the Volkswagen proposal—are the preventive care and the primary care programs included in that? Otherwise, you have the high copayments.

Dr. **Meyer**. Well, the proposal that I favor would be neutral. It would not specify a set of benefits. It would essentially say that you can have anything you want in your benefit package, but if the total exceeds that, you would have to pay a little tax on it.

I would like to see more insurance policies cover preventive types of care. In fact, I think one of the problems in the system is we have a bias toward high-cost institutional care and not enough——

Senator **Kennedy**. Right.

Dr. **Meyer**. I agree with that sort of benefit redesign under medicare, and I would encourage it. I am not convinced at all that the proposals I favor would discourage it.

Senator **Kennedy**. Well, I think in that sense we certainly agree. I think the practical reality is that they are the services that are generally the first to go, the primary and the preventive ones. That is the problem.

Dr. Schramm, I am very interested in the planning legislation. Do you have some interest in that? There is resistance by the administration. We see requests for hundreds of millions of dollars, even in my own State of Massachusetts, for new hospital beds, and we already have a surplus of beds.

I would be interested in your comments on the planning legislation. I wish we had more of our colleagues here to listen to it.

Dr. **Schramm**. Senator, the estimate, the very lowest estimate over the decade of the eighties, for new hospital capital construction is $83 billion. The highest estimate is $193 or $197 billion. This is extraordinary. It has grown immensely in the last 2 years since we have had the demise of the national health legislation, the national health planning legislation.

I think Assistant Secretary Rubin was quite correct, the record with regard to health planning has not been sterling. I think in large part the program was ill designed the first time out. However, because we have had a bad experience does not mean that the initial inclination is incorrect. We must have Government guidance, it seems to me, over the entire development of a constellation of providers. This is even more critical in the future with the projected increase in the number of physicians. Those physicians could, in fact, go into very stiff competition with hospitals.

Hospitals in New York, particularly in Manhattan, hospitals in Massachusetts, with quite grand designs on new capital construction, could essentially find themselves in the opening year of the new plant 60 percent occupied, without sufficient funds to pay the debt service.

I would recommend to you that there is a very new hospital in Michigan, the University of Michigan Hospital, where the debt service is over $400 per day per bed. Before a corpus goes in a bed and the sheets are wrinkled, the insurance company and the patient, the employers and the unions, have to come up with $400 just to pay the obligation on the debt service. That is an obligation that was contracted in the public bond market 4 years ago, with lower interest rates and a much lower cost of construction.

The most important, it seems to me, consideration, however, regarding health planning is the consideration of what a new dollar of capital expenditure means in terms of the requirements for operating revenues down the line, so that we often think about new capital only in the dimensions of how much this particular hospital will cost—$300, $400 million, or what have you.

The real thing to look at is not that, but rather the long-run obligations in terms of operating costs, new nurses, new suppies, new technology, all kinds of services that will attach to that in increasing amounts in the future.

Senator KENNEDY. My time is up.

Senator Denton.

Senator DENTON. Well, I want to express my admiration to both of you as witnesses. I have had Dr. Meyer before my subcommittee on several occasions, and he has always been an extremely valuable contributor to the subcommittee debate. Dr. Schramm seems to have a slightly different point of view but the same kinds of talents.

It seems to me not only a moral obligation, but a fiscal obligation that we do something about this discrepancy which presently exists by which the tax subsidies or failures to require some cost sharing on the part of the patient, irrespective of their income—that we must do something about that.

I know that this committee took President Reagan's tax cuts and sort of nullified his efforts. However, on the other hand, I will admit that those tax cuts were often offered in a basket. In other words, the cuts were done frequently with a butcher knife instead of with a scalpel. This was by necessity, because of what was happening to our inflation rate, and so forth, and we just sort of fought it out so that the Democrats on this committee generally, with a few Republicans, prevented the cuts he wanted.

Why can't we have a bipartisan, a multisectored commission composed of people from the medical profession, the nursing profession, the hospital equipment sector? I am not big on blue ribbon panels, but why can't we have one? Knowing the limitation on time that these gentlemen and ladies in the Senate and their staffs have, we just do not look that closely at it. We just can't.

We go out there on the floor and half the time we get a 20-second briefing on a vote that is critically important in some field. This field is full of such issues.

I ask you, Senator Kennedy—would you be in favor of some kind of a commission composed of that kind of a group to look into this over a limited time period, to come up with proposals, rather than have us hack away at it the way we are?

Senator **Kennedy**. I admire the interest of the Senator from Alabama and his willingness to address this issue in a comprehensive way.

My concern has been that the issue has been studied and studied and studied and studied right across the board.

The Senator is quite correct. It is a complicated problem. Institutionally, we do not deal with it effectively in the Congress. You have the financing of it in the Finance Committee and the basic delivery system here in the Human Resources Committee. Institutionally, we do not deal with it effectively.

You have to recognize that if you are going to deal with this issue in a comprehensive way, you have to deal both with the funding aspects of it and the delivery aspects of it and the quality aspects of it and the equity factors of it.

Senator **Denton**. If I may comment on that just in one sentence, not only does that apply to this particular field of health, but it applies to so many other of the welfare fields where Finance, Agriculture, our committee, and so many others have jurisdiction and then the various departments in the Government have it. What do we do? We simply cosmetically do things like delay the COLA's instead of really going at the institutional corrections required to those entitlements.

Senator **Kennedy**. Well, we can continue our dialog back and forth, but I think we have been fortunate to have two individuals who I think are committed to practical solutions. That is what we have to try to achieve. We have to find out what works. I think we have some experience about things that have worked. Dr. Schramm has talked about some of the approaches that have worked. Dr. Meyer has mentioned some of the areas. Each has expressed his own concern about what some of the faults have been in the past but I think, if we can on this committee focus on what works and what has a proven record and build on the issues of equity, we can have something that is important.

The **Chairman**. Thank you.

Senator **Kennedy**. I think that was mostly my time, Mr. Chairman. I again abused the Chair when he was absent.

The **Chairman**. I know. [Laughter.]

I assumed it.

Senator **Kennedy**. I trenched on Senator Denton's time.

Senator **Denton**. No.

The **Chairman**. We will just reduce your time with the other witnesses; that's all.

Do you have any other questions, Senator Denton?

Senator **Denton**. That is an overly kind interpretation. I asked Senator Kennedy a question, which I would have addressed also to you, Mr. Chairman, were you here.

I defer to the time which you and Senator Kennedy have spent on this issue before I came to the Senate. However, my question was directed at the need fiscally and morally to correct the discrepancies in this program by which those who can afford to pay are not being required to pay.

I did not even go into such nightmares, as I have learned personally from those who have done cost analyses on this system. For example, there was a study revealing that hospitals all over the

South were buying the Cadillac of beds in every case. In other words, there would be 12 beds that they could buy at different costs. All of them, since they were nonprofit institutions or institutions which were reimbursed on a cost-plus basis, would buy the Cadillac of beds and they didn't need that kind of bed. It was costing 10 times as much as the bed they needed. Nobody is looking into this.

My question was, why don't we let a commission get set up—and I am not wild about commissions, but the Hoover Commission was not that bad and I do not think the Scowcroft Commission did that bad a job. We just do not have the time, with all of the other splintered interests that we have, to do it.

Would you support an idea of forming a bipartisan commission consisting of doctors, nurses, hospital personnel, insurance representatives? It is a wild thought, but it is a desperate situation, looking at those charts.

The CHAIRMAN. Well, it is, and they do have a commission right now, but it may be that we will have to do more. Certainly, these hearings are pointing that up. Certainly, you two good witnesses have. We are very appreciative of the time that you have spent here today. We are particularly interested in that study, also. If you can submit that to the committee at the earliest convenience, we would appreciate it.

Dr. MEYER. OK. I will do it.

The CHAIRMAN. Thank you.

Our third panel represents various providers of health care services ranging from medical technology to medical care to hospital services and alternative systems for delivery of care.

First, I would like to welcome Mr. Dale R. Olseth, chairman-elect of the Health Industry Manufacturers Association. Accompanying Mr. Olseth is Mr. Harold Buzzell, president of the Health Industry Manufacturers Association. He will be our first panelist.

Our next panelist will be Dr. Joseph F. Boyle, chairman of the board of trustees of the American Medical Association.

We are glad to have you, Dr. Boyle, with us today.

Third will be Mr. Michael Bromberg, the executive director of the Federation of American Hospitals, and, finally, Dr. Donald Schaller, who is president of the Group Health Association of America.

We are very happy to welcome all of you gentlemen before our committee.

Again, I would like to limit your statements to 5 minutes before the committee, so that we have some time for questions. We will complete statements and make them part of the record as though completely delivered.

Mr. Olseth, let's turn to you first.

STATEMENT OF DALE R. OLSETH, CHAIRMAN-ELECT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION, AND PRESIDENT AND CHIEF EXECUTIVE OFFICER, MEDTRONIC, INC., MINNEAPOLIS, MINN., ACCOMPANIED BY HAROLD O. BUZZELL, PRESIDENT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION, WASHINGTON, D.C.

Mr. OLSETH. Thank you, Senator Hatch.

My name is Dale Olseth. I am president and chief executive officer of Medtronic, Inc., a health care company headquartered in Minneapolis. I testify today as chairman-elect of the Health Industry Manufacturers Association—HIMA—a trade association representing approximately 285 manufacturers of medical devices and diagnostic products. Accompanying me today is Harold Buzzell, president of the association and its chief executive officer.

HIMA commends the committee for these hearings. Health care costs represent a major issue for all of our membership. We appreciate this opportunity to share our perspective.

Discussions of health care costs often raise the question of whether we can afford technology. The question we ask in return is: "Can we not afford technology?"

Can we not afford the use of intraocular lenses to restore sight for those suffering from cataract disease? Can we not afford microsurgery, which allows physicians to attach a severed limb? Can we not afford infusion pumps to deal with the treatment of chemotherapy?

Health care technology offers Americans an unparalleled quality of life. But, in addition to quality, technology can bring economy to health care, reducing costs as well as suffering.

The purpose of our testimony today is to identify major groups of technologies that, properly managed, can help moderate costs. More to the point, we highlight technologies that can:

No. 1, improve hospital productivity;

No. 2, generate long-term savings; and,

No. 3, facilitate delivery of care in cost-effective settings.

Though my prepared statement discusses a number of technologies in detail, I only want to touch on a couple here this morning.

While many factors account for rising health care costs, surely declining productivity has been a major contributor. During the decade of the 1970's, health care employment rose from about 4 to 7 million workers, but output failed to keep pace, causing productivity to fall at an average of 1.4 percent per year annualized.

Productivity declines have resulted in large part from the way health care has been financed. Through cost- and charge-based reimbursement, the health care system has offered providers little incentive to be productive. On the other hand, prospective payment will now help change that. The new program will give hospitals strong incentives to improve productivity and ultimately reduce health care costs.

The first group of technologies I would like to discuss are those that can help hospitals achieve these goals. Indicative of this group is the multitest chemistry analyzer which helps diagnose a patient's condition more quickly, reduces length of stay in the hospital, and cuts per-test costs by as much as 500 percent.

Another, more simple, example is the electronic thermometer. The small, battery-powered device can measure a patient's temperature in about 30 seconds compared to previously 3 minutes. Because of this productivity improvement, electronic thermometers are now widely adopted throughout the U.S. hospital system.

A second group of technologies we believe can also help cut costs, but these produce savings to the entire medical system over time, not to an individual hospital upon discharge of a patient. These technologies argue strongly for the careful administration of prospective payment.

Because the technologies cost a little more up front, hospitals will not have the incentives to use them because they cannot reduce the cost of a patient's care below the established DRG reimbursement level. While they cannot help hospitals reduce costs on a per-discharge basis, we believe that medicare expenses in the long run can be reduced by reducing admissions.

A classic example is the implantable infusion pump, a device that will deliver continuous doses of drugs to the body. In liver cancer patients, the pump provides a continuous flow of chemotherapeutic drugs at a preset level, providing astounding medical and economic benefits. Medically, the response rate is running 80 to 85 percent compared to about 20 percent with conventional treatments.

The CHAIRMAN. Let me ask you a question, and you, also, Mr. Buzzell.

If I were inclined as the Labor Committee chairman to hold a special hearing on medical technology, would that be helpful to you? I think it surely would be helpful to this committee to look at some of the achievements that you people—when I say "you people," the people that you represent—have been able to attain in the last number of years, because it has been a tremendous explosion, as I understand it, in medical technology. Is that correct?

Mr. BUZZELL. That is correct.

The CHAIRMAN. Would that be helpful?

Mr. BUZZELL. Yes, it would.

The CHAIRMAN. I think it would make for a very interesting hearing. Would it be difficult to bring a number of these devices in here and explain them to the committee?

Mr. OLSETH. No. I would say that would be easily accomplished. We would welcome the opportunity.

The CHAIRMAN. Would a hearing be the way to go or would it be an exhibit in the, say, the Russell Building rotunda?

Mr. BUZZELL. The latter, I think, would be the best bet. We attempted that last year in a seminar presentation, and it paints a dramatic picture of technology.

What has happened is that not only is this technology enhancing the quality of life, and we all recognize how that happens——

The CHAIRMAN. But you actually can have cost savings.

Mr. BUZZELL [continuing]. But it has cost savings at the same time.

The CHAIRMAN. Yes. Because if you can do these things more efficiently and with less intensive labor costs, and less administrative cost, I suppose you are going to save money for hospitals and doctors and medical practitioners of all types in the long run.

Mr. **Buzzell**. Exactly. This example Mr. Olseth has mentioned is a dramatic example in the sense both of saving money but, more importantly of course, helping the cancer patients in the terminal stages of their lives.

The **Chairman**. The only reason I raise this is because I do not think people in America really have an appreciation of how advanced medical technology has become just in the last 10 years. I know I don't, and I am probably more familiar with it than most.

What I am asking you to do is this: I am willing to lend whatever support I can as chairman of the Labor Committee to help the American people become familiar with the tremendous advances and the benefits to mankind as a result of what your organizational manufacturers are doing.

I would like you to think about what is the best way of doing that because, of course, it needs to be publicized and people need to see it all over this country, whether it is a hearing or whether it is a public display or an exhibit, or whatever, but I think more has to be done by you and by us to help people be aware that medical technology isn't just a costly experience; it may be beneficial in many, many ways, including just assuming that it helps to save lives and improving the quality of care.

Mr. **Olseth**. Senator, in our case we have—this is our particular company—we have a device that is an infusion pump that will reduce the dosages of chemotherapy from 90 to 99 percent, and with that it eliminates or reduces all of the side effects of chemotherapy. It, in effect, is getting people out of the hospital, and all of the side effects that are associated with really the administration of chemotherapy are eliminated. Now that is still a clinical device, but it is coming out of the technology that is, in effect, in place in our industry. I think there are many examples of that.

That is our principal concern as we move to effect savings in health care. We all know that we have to get at the problem, and we want to do it.

With that, I will close my remarks, in order to hold to the 5 minutes.

[The prepared statement of Mr. Olseth and responses to questions asked by Senator Hatch follow:]

Statement of Dale R. Olseth
Chairman-Elect
Health Industry Manufacturers Association

Before the
Senate Committee
on
Labor and Human Resources

May 19, 1983

Mr. Chairman and Members of the Committee:

I am Dale R. Olseth, President and Chief Executive Officer of Medtronic, Inc., a health care company headquartered in Minneapolis. I testify today as Chairman-Elect of the Health Industry Manufacturers Association (HIMA), a trade association representing 285 manufacturers of medical devices and diagnostic products. Accompanying me is Harold O. Buzzell, President of the Association.

HIMA commends the Committee for these hearings. Health care costs represent a major issue for HIMA companies, both as developers of technologies and as employers that pay insurance premiums on behalf of hundreds of thousands of employees. We appreciate this opportunity to share our perspective.

Discussions of health care costs often raise the question of whether we can afford technology. The question we ask in return is "Can we not afford technology?"

Can we not afford intraocular lenses, which restore sight to cataract victims? Can we not afford microsurgery, which allows a physician to attach a severed limb and give it function?

Advances like these offer Americans an unparalleled quality of life. Through technology, many who yesterday were patients in institutions are today self-sufficient and productive members of society. But technology can do more than improve and save lives. It can bring economy to health care, reducing costs as well as suffering.

Too often, "technology" is discussed as if it is a were a single commodity. In fact, technology spans a variety of products and processes with diverse applications and economic consequences. The purpose of our testimony is to identify major groups of technologies that, properly managed, can help moderate costs. More to the point, the testimony will explain technologies that can:

- Improve hospital productivity;
- Generate long-term savings;
- Facilitate delivery of care in cost-effective settings.

The testimony will also suggest policy steps HIMA believes would enhance technology's potential for moderating costs. We begin by discussing the nature of the problem.

DECLINING PRODUCTIVITY: A MAJOR CONTRIBUTOR TO HEALTH CARE COSTS

Productivity in the Health Care System

While many factors account for rising health care costs, declining productivity has been a major contributor. In industrial, agricultural, and service industries, productivity advances have helped moderate costs. But health care has been different: The decade 1969-1979 saw continued declines in health care productivity, which added substantially to the costs of care for public and private payors.

During the decade, health care employment rose from four to more than seven million workers. But output (in real terms) failed to keep pace, causing productivity to fall at an average annual rate of 1.4 percent. This departed significantly from other industries, which registered productivity gains:

UNITED STATES PRODUCTIVITY TRENDS 1969 - 1979
(DOLLAR OUTPUT PER EMPLOYEE)

Average Annual Percent Change	Industry
-1.4	Health Services
0.7	All Services
1.7	Private Non-Farm
1.4	Finance and Real Estate
1.7	All Industries

Source: BUREAU OF LABOR STATISTICS, U.S. DEPARTMENT OF LABOR

Productivity in Hospitals

Declining productivity has been particularly severe in hospitals, where about 60 percent of costs are labor-related. Between 1972 and 1981, community hospital employment grew from two to three million workers, far outstripping modest growth in number of patients. As a result, the number of full-time equivalent employees per patient rose from 2.8 in 1972 to 3.5 in 1981. This translates into a 2.5 percent average annual decline in hospital productivity.

Misguided Incentives

Productivity declines have resulted in part from the way health care has been financed. Third-party payments have insulated patients from the true costs of care. In addition, the health care system has offered providers little incentive to be productive, since hospital costs and charges have been almost automatically reimbursed. This has rewarded inefficiency and encouraged utilization of services. Finally, the system's incentives have encouraged care to be delivered in inpatient settings, rather than cost-effective alternate sites.

TECHNOLOGY CAN HELP HOSPITALS IMPROVE PRODUCTIVITY AND REDUCE COSTS

Congress recently enacted hospital prospective payment -- a step HIMA applauds. The new program will give hospitals strong incentive to improve productivity and reduce health care costs.

Hospitals will be paid a fixed price for each Medicare inpatient they treat. If the cost of treating a case is less than the price, the hospital will retain the difference. The chance to profit from efficiency will encourage hospitals to cut costs in a variety of ways.

Under prospective payment, device and diagnostic companies will continue to supply cost-effective products to our hospital customers and develop labor-saving innovations to increase hospital productivity. The new payment system will simply bring into sharper focus the challenges we have always relished.

Prospective payment will challenge our industry to continue to develop productivity-enhancing technologies. The new cost-conscious climate will put a premium on these technologies; hospitals that adopt them will cut costs and more easily adapt to fixed prospective payment prices.

Providers will also have incentives to monitor closely the intensity of care inpatients receive. This will help insure technology is managed and utilized properly.

Productivity Through Advanced Technologies

Listed below are examples of advanced technologies that, properly managed, can increase productivity and reduce costs. The examples are indicative of the kinds of technologies prospective payment will encourage our companies to develop and hospitals to adopt.

Automated Multi-test Chemistry Analyzer

In the last 30 years, the hospital laboratory has evolved from a labor-intensive workshop to a sophisticated high-technology production center. Much of this progress is attributable to development of automated multi-test chemistry analyzers.

Analyzers are valuable diagnostic tools. By chemically analyzing blood serum and other body fluids, these machines help physicians diagnose a patient's condition more quickly and accurately than earlier methods, which relied on workers performing tests manually. The analyzers are "multi-test" because they can perform many different tests in the same batch.

The decade of the 1970's saw analyzers reduce per-test costs by as much as 500 percent. Much of this saving resulted from improved productivity.

The experience of one small community hospital illustrates the productivity gains that can be achieved with automated analyzers. As measured by the number of laboratory tests performed per hour of labor, productivity increased more than 15-fold over five years:

PRODUCTIVITY IN A SMALL COMMUNITY HOSPITAL LABORATORY

	1974	1979
Annual Volume of Chemistry Tests	12,972	25,934
Hours of Labor	5,481	730
Tests per Hour	2.3	35.5

Productivity gains like these have translated into reduced costs. After automating its laboratory, one large urban teaching hospital realized impressive savings in per-test costs:

LARGE URBAN TEACHING HOSPITAL

	1965	1975	Average Annual Percent Change
Total Tests	214,000	2,213,000	26
Total Laboratory Costs	$562,000	$1,126,000	7
Cost per Test	$2.63	$0.51	-15

In addition to cutting per-test cost, analyzers save money by reducing hospital length-of-stay. Because tests can be performed in a matter of minutes or seconds, diagnoses and treatments can be completed more quickly, reducing the time a patient must spend in the hospital.

Automated Cell Counter

Another valuable and cost-effective diagnostic tool is the automated cell counter, which measures a patient's blood cells.

The number and proportion of different cells indicate infection or other problems. Measuring the number of cells can help diagnose conditions ranging from anemia to leukemia.

Before introduction of automated counters, red and white cell measurements were performed by laboratory technicians using microscopes. This was a time-consuming process that was subject to human error.

Today, automated counters can record 16 different cell measurements in less than 30 seconds -- a job that would take four hours if done manually. By saving labor, the automated counter performs tests at one-tenth the cost of earlier methods (and with at least ten times the accuracy).

Like chemistry analyzers, cell counters help reduce inpatient length-of-stay. Less sophisticated counters can be used in physicians' offices and small laboratories.

Flow Control Device

The flow control device -- an automatic system to regulate and monitor the flow of intravenous (IV) drug solutions entering a patient -- is another cost-reducing product.

Conventional intravenous treatment requires careful monitoring by hospital personnel to insure that the patient receives the proper drug dosage, that the IV line does not clog, and that the bottle dispensing the solution does not run dry. That means nurses must set the IV flow level and check it frequently so they will be prepared to clear blocked lines and replace empty bottles.

By doing much of this work for nurses, the flow control device saves labor. Once the proper level is set, the device regulates the IV flow. If a line becomes blocked or a bottle runs dry, a warning signal sounds. The device reduces the need for constant IV monitoring, freeing nurses for other duties.

Through this increased productivity, the device saves approximately $7 per IV patient-day over conventional procedures. This translates into savings of about $1,400 per day for a 500-bed hospital with 200 IV patients.

Continuous Flow Device

Another advanced technology is the continuous flow intravenous set. These devices permit automatic transfer from one intravenous bottle to another during intermittent drug therapy.

Savings of $.87 per IV patient-day result, in part, because nurses do not have to make special checks to shut off one line and open another. For a 500-bed hospital with 200 IV patients, savings total $174 per day.

Patient Monitoring Systems

Through a melding of medicine and electronics, monitoring systems assess and record patient vital signs in a cost-effective fashion. Used widely in cardiac and intensive care units, these systems typically monitor five to thirty patients, measuring temperature, blood pressure, blood gas concentrations, and other important life signs.

In a cardiac unit, for example, electrodes attached to a patient's skin receive the heart's electrical signals. The signals are transmitted from the electrodes, through electrical circuits, to a console, where the signals are displayed on a screen. The console is at a central monitoring station, near consoles connected to other patients.

By watching the consoles, one nurse or a few nurses can provide sophisticated monitoring services to several cardiac patients. A console, for example, might display signals that indicate early stages of a heart attack. With this advance warning, treatment can be given the patient to prevent the attack.

In addition to providing high quality care, monitoring systems are labor-reducing and cost-effective. By centralizing information, the systems allow better scrutiny of patient conditions and free nurses to provide direct patient care.

Chymopapain Therapy

The new drug chymopapain can be a cost-effective treatment for painful herniated disks.

A physician injects the drug into the disk to dissolve it, eliminating the need for expensive back surgery. Chymopapain can be administered for about $1,500 -- half the cost of the surgery.

In addition to its cost-effectiveness, this drug therapy saves patients the trauma of surgery.

Productivity Through Technologies That Are Non-Invasive Or Less Invasive

The productivity of some advanced technologies results from the fact that they do not "invade" the body, or they do so less than alternate procedures. Because they often eliminate the need for major surgery, these technologies save hospitals money and patients trauma.

Diagnostic Imaging

Technologies developed in the last ten years have dramatically improved our ability to obtain diagnostic images of the heart and body. These technologies generate sophisticated information quickly, allowing prompt attention to problems and often eliminating the need for more costly or dangerous diagnostic and therapeutic procedures.

Several imaging technologies are available to physicians. Computed tomography constructs images of thin slices of the anatomy. Nuclear magnetic resonance allows physicians to visualize not only the structure but also the metabolism of internal body tissues. Ultrasound uses sound waves to produce pictures of heart motion and fetal activity.

Technology even makes conventional x-ray procedures more efficient. Digital subtraction radiography enhances x-ray sensitivity by removing tissue shadows obstructing the organ being viewed. Automated control systems eliminate the need for re-shooting x-rays, saving at least $12,000 per year for each x-ray room so automated.

These technologies offer several economic advantages. They are noninvasive, allowing accurate diagnosis (often on an outpatient basis) without costly exploratory surgery. In addition, they eliminate unneeded diagnostic and therapeutic procedures that would have been performed on the basis of less precise diagnostic information. Because the information is precise, it helps insure that any procedure performed will be carefully targeted. Finally, these technologies help physicians complete diagnoses quickly, reducing inpatient hospital stays.

Coronary Angioplasty

A new and highly productive technological innovation is coronary angioplasty -- the use of a "balloon" catheter to open obstructed arteries near the heart.

In this procedure, a physician inserts the balloon catheter into an artery in the patient's arm or neck. The physician "steers" the catheter through the body until it reaches the obstructed artery. The balloon is then inflated, opening the blockage.

Coronary angioplasty is less invasive and less expensive than the alternative treatment -- heart bypass surgery. While bypass surgery costs about $15,000, the balloon catheter procedure can be performed for $3,000 to $5,000. Since coronary angioplasty could substitute for five to ten percent of the 100,000 bypass surgeries done each year, potential savings are substantial.

In addition to cost savings, coronary angioplasty allows patients more rapid recoveries, enhancing quality of life.

Productivity Through Devices With Low Unit Costs

The examples above illustrate sophisticated technologies that improve productivity and reduce costs. Complementing these advances are relatively simple and inexpensive devices that bring cost savings to hospitals.

Electronic Thermometer

To take patients' temperatures, providers are increasingly employing labor-saving electronic thermometers -- even the Capitol physician's office uses them.

Electronic thermometers are small, battery-powered devices that allow a nurse to measure a patient's temperature in 30 seconds (compared to three minutes for mercury thermometers). The device serves as a receptacle for a disposable tip used for each patient. After the patient's temperature is measured, the tip is discarded, saving sterilization costs and reducing the chance of infection.

Durable and convenient, the electronic thermometer is an important contributor to the productivity of routine patient management.

Trays and Packs

Trays and packs are sterile packages that contain an assembly of single-use items used in various medical and surgical procedures. By eliminating the need to assemble and sterilize devices before each procedure, trays and packs save labor and improve productivity.

The epidural anesthesia tray, for example, is used to administer the common spinal anesthesia for childbirth. The tray contains the skin preparations, needle, tubing, and connector devices needed to deliver the anesthesia solution. Stocked in labor rooms, the trays are readily available to hospital personnel.

Surgical packs serve a similar purpose in operating rooms. Molded to the requirements of selected procedures, these packs contain the appropriate kinds and quantity of sterile drapes, sponges, bandages, and related materials. In addition to saving labor, packs provide an assurance of sterility not possible when hospital personnel assemble the many small items used in surgery.

Not immediately obvious are the inventory costs trays and packs save. Because they can more easily predict consumption of trays and packs, hospitals can adjust inventories more precisely. In addition, inventory handling costs for trays and packs are less than the costs of handling a large number of individual items.

Pre-mixing of Drugs

Pre-mixing of drugs can also improve productivity while enhancing quality of care.

Hospitals themselves have traditionally filled IV bottles with drugs and other solutions. This requires substantial labor, equipment, and administrative costs. In addition to expense, however, the process is far from ideal medically. Improperly mixed solutions create waste and potential harm for the patient.

Today, hospitals can forego this process and buy IV packages that include pre-mixed drugs, avoiding labor and administrative costs and cutting waste. In addition, pre-mixing improves quality, since the drugs are prepared under carefully-controlled settings outside the hospital environment.

Potential savings are substantial. For example, premixing theophylline -- a muscle relaxant and vasodilator -- could yield savings of as much as $1.06 per dose. For 25 doses per day -- typical for a

500-bed hospital -- savings would be about $26.50 per day, or $9,672.50 per year.

Hydrogen Peroxide Technique

Another productivity-improving technology is the use of hydrogen peroxide to control bacteria in urinary drainage bags.

Urinary tract infections occur in 15 to 25 percent of catheterized patients. The infections often result because bacteria enters the drainage bag and, eventually, the patient.

One new technique substantially reduces chances of infections. It allows the periodic addition of hydrogen peroxide to a specially-designed drainage bag that seals out bacteria.

This simple procedure also provides considerable savings. The costs of treating urinary tract infections in an average hospital are $82,650 per year. Yet the cost of treating patients with this new procedure is approximately $13,500 -- providing the same benefits at less than one-sixth the cost.

Policy Recommendations

Prospective payment will give hospitals incentives to act in their economic self-interest. The opportunity to profit from reduced costs should exert a favorable influence on productivity.

HIMA recommends the Committee carefully scrutinize programs that will dilute the positive incentives of prospective payment. One such program is health planning, which HIMA believes is unnecessary.

Health planning requires a hospital to obtain a certificate-of-need before major medical equipment can be acquired. This is the case even if the equipment will help the hospital reduce its operating costs below DRG rates.

By subjecting equipment purchases to regulatory controls, health planning will prevent or delay adoption of technologies hospitals judge to be productivity-enhancing and cost-effective.

Prospective payment underscores the fact that health planning is unnecessary. We therefore reiterate our view that the health planning law should be repealed.

TECHNOLOGY CAN GENERATE LONG-TERM SAVINGS

A second group of technologies can produce long-term savings by reducing hospital admissions.

Without careful administration, prospective payment will give a hospital no incentive to adopt a technology in this second group. The reason is that the technology will simply not help the hospital reduce the cost of a patient's care below the DRG price. The economic benefit the technology provides -- reduced admissions -- accrues to Medicare over time, not to the hospital upon discharge of a patient.

In administering prospective payment, we should not be penny wise and pound foolish. We should not discourage development of technologies that may cost a little more up front, but save millions down the road.

Implantable Infusion Pump

A classic example is the implantable infusion pump -- a device that delivers continuous doses of drugs to the body. In addition to generating long-term savings, the pump allows high quality treatment of cancer, cardiovascular diseases, diabetes, and severe pain.

The pump, implanted below the skin, provides a continuous flow of drugs at a preset level. In treating liver cancer, for example, the pump is implanted so that a small catheter connects the pump to the artery that feeds the liver. This assures that a limited, highly concentrated amount of chemotherapeutic drugs flows directly into the cancerous tissue, increasing exposure to the drugs and improving the patient's chances for recovery. By targeting the liver, the pump minimizes side effects, allowing patients to work and lead full lives.

To appreciate the infusion pump's economic and therapeutic advantages, consider the alternative. In conventional treatment of liver cancer, a patient enters the hospital frequently to receive large doses of toxic cancer drugs. Side effects are so severe that the patient can receive treatments for only about two weeks, followed by recuperation at home for one to two months. After recovery from the treatment, he must reenter the hospital and begin the process again. In sum, conventional treatment has meant repeated and expensive hospital stays, accompanied by extensive physical side effects.

The infusion pump has proven more effective than conventional treatment -- both medically and economically. Medically, the response rate for liver cancer patients using pumps averages 80 to 85 percent, compared to 20 percent for those treated conventionally.

Economically, the pump yields savings of 60 to 65 percent in the first six months alone. One study found that the average cost per day for patients using the pump was $115, compared to $559 for other liver cancer patients.

Savings result from the pump's ability to reduce hospital admissions. After the pump is implanted, the patient need not return to the hospital, since drugs can be added to the pump on an outpatient basis. In all, one study showed the pump can extend the average patient's life 23.5 months at less cost than conventional methods require to extend life 5.5 months.

Despite this cost-effectiveness, the initial price of $3,000 may seem prohibitive to hospitals under prospective payment, since they do not benefit from the reduced admissions made possible by the pump. This argues strongly for a prospective payment system that accommodates long-term cost-effectiveness.

Multiprogrammable Pacemaker

Another cost-effective product is the multi-programmable pacemaker. Most pacemakers sold today can be reprogrammed without surgery. By adjusting one of several functions -- such as rate, stimulation, output, and sensitivity -- physicians can adjust for changing conditions and resolve patient problems without additional surgery.

Several studies have shown multi-programmability to be cost-effective. In a recent clinical study of 140 pacemaker patients, for example, 44 patients had clinical complications associated with their pacemakers. In 33 of these patients, the physician was able to correct the complication by reprogramming. In the absence of programmability, the complication would have required surgery. The study concluded that net financial savings exceeded $65,000 for the 13-month study.

Policy Recommendations

To limit bias against products like the implantable infusion pump and multiprogrammable pacemaker, prospective payment provides mechanisms to update DRG prices and create new DRGs. More broadly, these mechanisms are designed to help prospective payment accommodate technological advances.

Chymopapain therapy -- the technology that can eliminate back surgery -- illustrates the need to keep DRGs current. Because this therapy is new, it may not be easily accommodated by the appropriate medical DRG, even though surgery would be twice as expensive. If this is the case, hospitals will have incentives to perform the surgery, since it is an established procedure and likely to be accommodated by the price of the appropriate surgical DRG. To avoid perverse incentives like these, DRGs should be adjusted to encourage treatment in the most cost-effective fashion.

The Secretary of Health and Human Services will have authority to make DRG adjustments. In doing so, the Secretary will receive recommendations from an independent commission to be created under the auspices of the Office of Technology Assessment (OTA).

HIMA observes that three members of this Committee -- including the Chairman and ranking minority member -- serve on the OTA Board. For that reason, we take this opportunity to indicate our strong support for the OTA Commission and the constructive role it can play in keeping DRG prices current.

Specifically, HIMA recommends two actions. First, fiscal year 1984 funds should be appropriated to insure the Commission can begin its important work next year. Though the Appropriations Committees have jurisdiction over this matter, we believe it important to inform you of the need for adequate Commission funding and solicit your support.

Second, HIMA urges this Committee to monitor the performance of the OTA Commission and the Secretary in adjusting DRGs and DRG prices to reflect new technologies. Without careful adjustments, prospective payment could discourage development of cost-saving technologies like infusion pumps, multiprogrammable pacemakers, and chymopapain therapy.

SYSTEM-WIDE PRODUCTIVITY

Prospective payment -- coupled with an effective DRG adjustments process --is a first step toward improving the productivity of hospital inpatient care. But to begin to moderate costs in the health care system as a whole, productivity should be encouraged wherever it can be generated -- in ambulatory and home settings, as well as hospitals.

The final section of our testimony discusses the important role technology can play in facilitating delivery of care in cost-effective, non-inpatient settings. We begin the discussion by examining some of these settings and their records of cost-effectiveness.

Cost-Effectiveness In Non-Inpatient Settings

Many treatments and diagnoses can be provided outside the hospital. Even chronic health problems faced by the growing numbers of our elderly -- diabetes, digestive disorder, and arthritis -- can be treated in non-inpatient settings. The surgicenter, emergicenter, and home provide three examples of how non-inpatient care can be convenient for the patient and cost-effective for the system.

Surgicenters

At an ambulatory surgicenter, a patient can have surgery performed without spending a night in the hospital. By reducing hospital stays, surgicenters save health care dollars. One study, for example, found surgicenter charges for selected procedures were 55 percent less than inpatient hospital charges:

FREESTANDING SURGICENTERS

Procedure	Hospital Inpatient Charges	Surgicenter Charges
D&C (non-abortion)	$297	$119
Lapcroscopy	$280	$131
Myringotomy	$273	$130

Source: ORKAND CORPORATION - 1977

Emergicenters

A second example is the freestanding emergicenter. Like a hospital emergency room, the emergicenter treats minor surgical and medical cases and, in some cases, stabilizes acutely ill patients. Despite the similarity in cases treated, emergicenter charges, according to one study, averaged 25 to 60 percent less than charges at hospital emergency rooms:

FREESTANDING EMERGICENTERS

	Hospital Emergency Room Charges	Freestanding Emergicenters Charges
Corneal Abrasion	$97	$40
Upper Arm Laceration	$133	$75
Arm Fracture	$157	$71
Influenza with Fever	$159	$30
Upper Respiratory Tract Infection	$136	$34
Average Charge	$115	$42

Source: ORKAND CORPORATION - 1982

The Home

Another non-hospital setting — the home — is becoming an increasingly popular health care delivery site. Besides offering patients the convenience and comfort of familiar surroundings, home care is available at substantially less cost than care in hospitals and other institutional settings.

Much of this saving is made possible by technology. In the next section of the testimony, we discuss technologies that facilitate delivery of care in the home and at other non-inpatient sites.

Technology: Catalyst To Cost-Effectiveness In Non-Inpatient Settings

While many factors account for the cost-effectiveness of care in non-inpatient settings, technology plays a particularly important role. The examples below show how a final group of technologies makes cost-effective care at alternate sites possible.

Bone Growth Stimulator

The bone growth stimulator uses electromagnetic signals to help mend bone fragments in a process resembling normal healing.

One form of the device requires no incision and is simply applied to the cast over the fracture. After initial prescription and fitting by a physician, patients themselves typically perform the treatments at home. Since the electromagnetic signals are painless, the device can to be used while sleeping.

This device has been used successfully on 77 percent of the 10,000 patients who have completed treatments -- many with severe fractures that other procedures had failed to mend. A 22-year-old man suffering from a broken tibia, for example, had undergone four years of unsuccessful surgical treatment. Despite the severe nature of the injury, the bone growth stimulator healed the fracture in only a few months.

These therapeutic benefits are accompanied by considerable cost savings. The treatment can be administered in the home for an average lease cost of $3,300 to $3,500 per patient, including physicians' fees. The alternative treatment for a fracture is a surgical procedure that requires seven to ten days of hospitalization and costs, on average, $6,500 to $7,200.

Fiberoptics

Fiberoptics covers a set of diagnostic and therapeutic procedures that are less invasive than alternative procedures, and, as such, can be performed in outpatient settings. Because patients suffer less trauma, they have more rapid recoveries.

A patient, for example, may have stomach discomfort, indicating a possible ulcer. Instead of doing costly and traumatic exploratory surgery, a physician can diagnose the problem by using a fiberoptic instrument to look inside the patient's stomach.

Resembling a thin straw, the instrument is made of fine glass flexible enough to bend. After being inserted into the patient's nose or mouth, the instrument is guided by the physician until it reaches the stomach. A light projected through the glass tube allows the physician, aided by a magnifying lens and television screen, to examine the site of the problem.

Another fiberoptic procedure is arthroscopy, which allows diagnosis and repair of knee-joint injuries on an outpatient basis. Functioning as a miniature telescope, an arthroscope can be inserted into the knee, permitting an orthopedic surgeon to view knee tissue. If this diagnostic procedure reveals that treatment is required, it can be performed immediately.

Because the procedure requires only a small incision, patients suffer less trauma and can return to work in one or two days, instead of the three-week convalescence required after conventional inpatient surgery.

CAPD

Continuous Ambulatory Peritoneal Dialysis (CAPD) is a cost-effective kidney dialysis technology that enhances the quality of life.

Conventional dialysis requires blood to be pumped outside the patient's body so wastes and excess water can be removed. During this treatment, the patient is connected to a dialysis machine.

In contrast, CAPD allows dialyzing fluid to drain from a plastic bag into the patient's abdominal cavity, where the body's peritoneal membrane performs the filtration function. Except for the time required to drain the fluid into the abdominal cavity, the patient is ambulatory.

CAPD provides substantial economies. The procedure is performed at home and eliminates the need for blood-thinning drugs. On an annual, per-patient basis, CAPD costs, on average, $1,874 less than conventional dialysis performed in an institutional setting.

Infusion Technology

Development of pumps and infusion devices has facilitated the movement of several life-sustaining therapies into the home, including the two described below.

Parenteral and enteral nutrition comprise the first such therapy. These advances provide life-sustaining nutrients to patients who have lost their ability to eat and absorb food, because of cancer or other gastrointestinal problems.

Both enteral and parenteral nutrition use electronically-controlled pumps to infuse patients with specially prepared nutritional supplements. For patients with complete loss of digestive ability, total parenteral nutrition (TPN) is administered through a catheter placed in a large vein near the heart or in the arm or leg.

In general, enteral nutrition is used for patients who retain some gastrointestinal functions, but who cannot eat in a normal manner. Tubes containing nutrients are inserted through the nose into the stomach or are surgically inserted into the stomach or small intestine.

TPN and enteral nutrition have several benefits. They enhance healing and chances of recovery, permit patients to lead more normal lives, and allow treatment in the familiar surroundings of the home at less cost than inpatient care. Even when administered in the hospital, these therapies reduce length of stay.

Efficiency of home nutritional therapy over hospital-based treatment is striking. A 1978 study by the Cleveland Clinic Foundation, for example, found TPN was 73 percent less expensive in the home than in the hospital. The costs were computed on a daily basis, with home TPN costing $54 per day and hospital treatment $202.

A second infusion technology makes treatment of infections possible in the home, avoiding the six-week hospital stay often required to treat infections on an inpatient basis.

Syringe pumps and other devices allow infusion of antibiotics at home at substantial savings:

HOME ANTIBIOTIC THERAPY

Study	Year	Average Treatment Cost		Averge Cost/Day	
		Inpatient	Home	Inpatient	Home
University of Oregon Study, Portland	1977	$5,060	$1,526	$230	$69
Methodist Hospital Study, St. Louis, Minn.	1977	$2,231	$ 611	$131	$36
University of Manitoba Study, Winnipeg, Manitoba	1978	$3,151	$ 920	$137	$40
Fairfax Hospital Study, Falls Church, Va.	1980	$3,442	$ 797	$172	$40
Methodist Hospital Study, St. Louis, Minn.	1981	$4,623	$1,170	$271	$69

Artificial Hip

Hip joints have emerged in the last decade as a remarkable treatment for a number of different hip diseases. In addition to its therapeutic benefits, this technology allows patients to live at home and avoid costly long-term care in an institution.

Patients with hip problems due to osteoarthritis, fracture, dislocation, rheumatoid arthritis, or asceptic bone necrosis formerly faced lives of incapacitating pain and joint dysfunction. But with new artificial hip joints, these patients are now able to return to normal and productive lives.

Every year, 75,000 hip joints are implanted in 65,000 patients (some patients have both joints replaced). After several months of recuperation, these patients are able to assume once again the many responsibilities of daily living.

While the cost of implanting hip joints can exceed $5,000, the surgery frees the patient from debilitating illness and saves many thousands of dollars in long-term expenses otherwise required to care for the incapacitated patients. Additionally, forty percent of joint implants are provided patients who are less than 65 years old, and many of these patients return to work. Hip joints thus represent an important therapeutic procedure that returns a net benefit to society because patients are restored to normal and productive lives.

Policy Recommendations

Unfortunately, health care financing has not always effectively utilized innovative health care delivery. In Medicare and other public programs, incentives encourage delivery of care in hospitals and other insitutions, even though less expensive alternatives are often available. To readjust these incentives, HIMA recommends two initial steps.

First, Congress should look closely at current cost-sharing requirements, which give patients incentives to seek care in more expensive institutional settings. Modifying these requirements could encourage delivery of care at alternate sites.

Second, the feasibility of extending prospective payment to alternate sites should be explored. The Health Care Financing Administration is beginning research on this approach. We encourage Congress to monitor and support this research.

Steps like these represent initial efforts toward rewarding efficiency in the health care system as a whole, not just in hospitals.

CONCLUSION

Technology can play an important role in moderating health care costs. It can improve hospital productivity and generate long-term savings. In addition, technology can facilitate delivery of care at cost-effective sites.

HIMA stands ready to assist the Committee in exploring policies to moderate costs.

Questions for Mr. Olseth

1. There are some people who claim that technology has increased health care costs. Do you agree that some technology can be cost-effective; that the cost problem is associated with over-utilization of these technologies?

   Indeed, much technology is cost-effective. For example, a tremendous amount of our equipment actually cuts labor costs. Such technologies--such as the chemistry analyzer that I mentioned in my prepared statement--increase productivity by permitting either reductions in staff or use of existing staff in other areas. In addition, many medical technologies substantially reduce hospital stays and allow low-cost outpatient and home care. Good examples are the bone growth stimulator, ambulatory kidney dialysis, and many more.

   I might add that, to the extent over-utilization has occurred in hospitals, the prospective payment system will curb excessive usage or testing.

2. What should be done to assure that prospective payment does not harm or thwart technological advances?

   First of all, the system should be responsive to changes in treatment and technology. That means frequent rate updates and changes in DRCs to reflect new technologies. Beyond that, the expert Commission that will advise the Secretary is critical. It deserves full Congressional support and should include members knowledgeable in the role of technology in health care. Finally, prospective payment must be administered properly. Technologies which greatly increase productivity for the Medicare system in the long term, but which cost hospitals more money initially, should be accommodated. To do this, DRG rates must allow the hospitals to make the up-front investments necessary to provide these forms of care and generate system-wide savings.

3. How can we maintain high quality health care while controlling health care costs?

   First, we should increase productivity. Simply stated, that means get more care, treatment, and service out of the available resources. Secondly, we should encourage technology that cuts costs but increases quality. Much of our technology does just that. And the new prospective payment system will allow such technology to show how productive it really is.

4. To what extent are alternative delivery sites the answers to high health care costs? And do you agree that home health care is a cost-effective means for treating many outpatients?

    Alternative delivery sites are critical. Studies show that such sites--emergicenters,surgicenters, outpatient care--are all cheaper than in-patient care. As I stated in my testimony, our technology helps make such treatment possible. But there's more than savings involved. Such treatment also improves the quality of life, keeps people on the job more often, and even enhances the quality of the care.

    Home health care is certainly also a very practical, very beneficial alternative--both for the patient and for health care costs. I don't think there is any doubt that home treatment allows patientsto lead a more normal, pleasant life. But it also can play a large role in providing lower-cost health care treatment.

    Unfortunately, current public and private insurance systems were not designed to encourage people to be treated in low-cost settings like those I have just mentioned. It is important for the proper set of financial incentives to exist for patients and providers to seek and deliver care efficiently.

The CHAIRMAN. Thank you, Mr. Olseth.

I would like you to think about that because I think something needs to be done in that area. I will be happy to help in any way I possibly can.

Mr. BUZZELL. We appreciate that very much.

The CHAIRMAN. I know you have annual conventions, and so forth, to demonstrate some of these. However, maybe it is important to get a maximum exposure to the public, especially to members of the national legislative bodies. We need to be more aware of these things.

Mr. BUZZELL. We appreciate that very much.

The CHAIRMAN. Thank you.

Dr. Boyle.

STATEMENT OF JOSEPH F. BOYLE, M.D., CHAIRMAN OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, LOS ANGELES, CALIF., ACCOMPANIED BY ROSS RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION, AMERICAN MEDICAL ASSOCIATION

Dr. BOYLE. Good morning, Senator.

Mr. Chairman, I am Dr. Joseph Boyle, an internist from Los Angeles. I am chairman of the Board of Trustees of the American Medical Association. With me is Mr. Ross Rubin, who is the director of the AMA's Department of Federal Legislation.

You have our full report, and I will simply outline some of the features of that.

The increases in health care costs have long been a concern of the American Medical Association. At the same time, we believe that it is necessary that, as Mr. Olseth has just pointed out to you, what we are talking about is providing services to people in this country that simply were not available as recently as a decade ago.

Second, we are talking about a delivery system in the United States which is acknowledged to be the finest in the world, and it is a delivering a kind and availability of service that has never been enjoyed by any country in the world, nor is enjoyed any place else today.

At the same time, we are not unique in the amount of resources that we have allocated to health care in this country. In fact, until quite recently, the resources allocated in the United States were, in fact—the increase in resources was actually below that in many other countries in the western world.

We also, at the same time, are providing care for larger numbers of people. People have access to a quality of care that was unthought of in the past and, because of increases in technology, that service is now available to larger numbers of people.

There are several factors that have gone into the increases in cost, one of which is simply inflation. That is approximately 57 percent of the increase in health care costs in the United States over the past 10 years.

The CHAIRMAN. I might mention on that point that a lot of people are missing this. When you have inflation at double-digit rates, it is pretty tough to keep health costs down. We might still be having the effects of that double-digit inflation as it gradually winds down. At least I hope that is true.

Go ahead. I am sorry to interrupt.

Dr. BOYLE. Second, we also take recognition of the fact that some increases in cost have not been associated with a benefit to society or to individuals. As a consequence, our association is committed to identifying unneeded or unnecessary costs, and we are committed to trying to make the system more cost efficient, though at the same time care effective.

There has been a tremendous increase in the technologies in medicine, much more sophisticated and being continually improved. While some of these increases in technology do not guarantee a provision of high quality health services, it cannot be denied that expenditures for this technology have served to improve the quality of life for people in this country.

One of the major factors involved in the increases in cost, particularly to the Federal Government under medicare, has been simply the increase in the population of the elderly in this country. From 1950 to 1980, the population of the United States over the age of 65 doubled from a little over 12 million to 25.5 million people, and it is projected that by the year 2000 that there will be 36,251,000 people over the age of 65 in the United States. This is coupled with the fact that expenditures for medicare-eligible people approximate $2,000 a year, whereas for people who are under the age of 65, this cost is somewhat less than half of that.

The combination of both of these factors has increased the cost for the Federal Government under medicare and other programs.

We are at a point now where the United States may have reached a state in which the sustained economic growth cannot be sustained, and society is going to have to make some very serious choices. However, as society makes those choices and as the Federal Congress becomes involved, we are most anxious that changes that are made today do not place in jeopardy the continued availability of high quality health care for future generations of any age.

We are dedicated to the provision of the best possible medical care to patients in need of care. In the past we have run into ethical dilemmas such as that which is posed by people with end-stage renal disease. The Federal Congress a couple of years ago decided that it would resolve that problem by making chronic renal dialysis and renal transplant and other management for people with end-stage renal disease available to everyone under medicare. Now it is quite likely that individual beneficiaries under this program or their families would not object to the expense of this entire program, but it does mean that there are choices that are being made on occasions in an irrational fashion. Choices or decisions that would have been made based on medical ethics, based upon moral and other judgments, based upon sound, scientific individual physician's judgment have been made in fact by a Federal law and regulations that are attendant upon it.

We have recognized something that Senator Denton pointed out for quite some time. That is that no one has been looking at the health care delivery system and the infrastructure upon which it rests in this country as a whole. Not infrequently we are looking at a renal dialysis program or a cancer research or therapy program or looking at maternal and child welfare or some other such program as though they existed in the abstract or existed in a vacuum; whereas, in fact as you impact one part of the system, as you start to pay for people who are disabled, for example, or as you start to pay for people who are the recently or chronically unemployed, you are going to impact some other part of the system.

As a consequence, beginning approximately a year, the American Medical Association did convene a group of now about 150 different organizations to develop a health policy agenda for the people of the United States. We intend to look at the principles which we believe make this system work, and only after we have reached consensus among not only physicians, but nurses, technologists, hospitals, insurers, business, labor, and the general public—when we have reached consensus on principles which we can identify as being definitively related to the economic, scientific, educational, and political circumstances facing this country, we will ask that decisions be made on policy.

We are committed to this program. We have allocated about $3 million of our resources. We are approximately one-half way through—pardon me—a little bit less than one-half way through the project. We are quite optimistic that we will be able to make recommendations that will have a long lasting impact.

The CHAIRMAN. That is great. Let me commend you for that. I think that it is crucial that you really continue and get that done, because there is a real cry and demand here in the Congress, as you can see, for a wide variety of programs to contain health care costs. Any help that the industry, and doctors in particular, can give us is going to be very helpful and beneficial to this committee.

There is a wide disparity of belief on our committee, as a matter of fact. Anything you can do to continue to help us, we would appreciate it.

We appreciate your testimony here today.

[The prepared statement of Dr. Boyle follows:]

STATEMENT

of the

American Medical Association

Committee on Labor and Human Resources
United States Senate

RE: Health Care Costs

Presented by:
Joseph F. Boyle, M.D.

May 19, 1983

Mr. Chairman and Members of the Committee:

My name is Joseph F. Boyle, M.D. I am a physician in the practice of Internal Medicine in Los Angeles, California, and I am Chairman of the Board of Trustees of the American Medical Association. Accompanying me today is Ross N. Rubin, the Director of the AMA's Department of Federal Legislation. The American Medical Association is pleased to have this opportunity to present this testimony on the cost of delivering health care services in this country.

The American Medical Association recognizes that health care costs in this country have been steadily increasing. In 1965, total health care expenditures were approximately $39 billion and represented 5.9% of the gross national product (GNP). In 1982, these figures had increased to approximately $321 billion, and the percentage of GNP for health expenditures was at approximately 10.5%. The Administration's projections indicate that total health care expenditures will exceed $750 billion by 1990, and this will account for approximately 12% of the GNP. Mr. Chairman, while these figures are indeed large and do give cause for reflection, it is important to consider the fact that these figures represent the totality of the delivery of health care services and reflect a mix of health care services that were simply not available to the people of this country as recently as a decade ago.

There has been a great deal of concern expressed about the growth of health care expenditures in this country. It is important to point out, however, that the United States is in no way unique in the amount of resources allocated to health care. Available data show that the average annual rate of increase for health care expenditures experienced in the United States was less than that seen in many other western nations. The average annual rate of increase for total health care expenditures in the United States from 1969 to 1976 was 12.5%. However, this figure was higher in Australia (20.5%), Finland (18.9%), the Netherlands (18.4%), the United Kingdom (18.2%), West Germany (17.7%), France (16.5%), Sweden (14.6%), and Canada (14.3%). In addition, the analysis of national health expenditures in these nine countries indicates that the percentage share of GNP for health care expenditures in the United States is not out of line with that of other countries. While the share of GNP in the United States was 8.7% in 1976, Netherlands, West Germany, France, and Sweden all had percentage expenditures greater than 8.2%, Australia, Finland, and Canada all had expenditures greater than 7%, and only the United Kingdom had an expenditure that was less than 6%. By pointing out these national health care expenditure figures for other countries, we are pointing to the fact that the United States is not alone in recognizing the importance of health care for its citizens.

During the course of these hearings and future considerations, we urge you to recognize the fact that all health care cost increases cannot and should not be considered in a negative light. Significant elements of these increases in costs reflect the fact that large numbers of individuals now have better access to a quality of health care that was almost unthought of as little as ten years ago, reflecting more advanced and technologically-improved health care services. Furthermore, it cannot be overstated that the population of this country is aging and placing greater demands on the health care delivery system.

Health care within this country is not provided in a vacuum, and it is not immune to outside market forces. A significant percentage of health care cost increases is attributable directly to the severe inflation that has beset our economy. The AMA does recognize that some cost increases have occurred without an equal return through better access to care or to a better quality of care, and we have been taking positive actions to contain those health care costs that are inappropriate and that are not benefitting the public. Before detailing the activities of the AMA to help contain such costs, consideration must be given to national trends and priorities that demand consideration in future deliberations on health care costs.

Technology

A review of health care costs in this country cannot be divorced from the fact that the mix of services available involves more sophisticated technology that is being continually updated. While improved methods of treating patients through new technologies cannot guarantee the provision of quality health care services in all instances, it cannot be denied that expenditures for technological advances have served to improve the overall quality of health care that is available.

An example of a technological breakthrough that has virtually revolutionized the field of diagnostic radiology is the use of the computed tomography (CT) scanner. The use of CT scanners has dramatically changed the means of treating many patients. Improved imaging technology has greatly reduced the use of more expensive, more risky and uncomfortable invasive procedures. While the initial costs of this equipment caused great concern, it was soon realized that this technology was an important improvement in patient care. Yet even today, while CT scanners have started to become commonplace, they are becoming obsolete. The Food and Drug Administration is currently in the process of considering whether or not to grant marketing approval for a nuclear magnetic resonance imaging device that takes clearer, more detailed pictures than even the latest model CT scanner. This is just one example of the evolutionary process and concomitant expense that is inherent in the development and use of medical technology.

The Aging Population

The federal responsibility for health care coverage through Medicare and also total health care expenditures will increase over time as the population and elderly population in particular increases. There will be substantial increases in the elderly population over the next fifty years, and this is particularly important as the elderly have historically utilized a greater proportion of health care resouces. From 1950 to 1980, the population in the United States of individuals over the age of 65 doubled from 12,334,000 to 25,544,000. Projections through the year 2030 indicate that this population will again double, reaching 36,251,000 in 2000 and 64,925,000 in 2030. In addition, an article from the March 1983 issue of _Health Care Financing Review_ points out that the population of those over age 75 is projected to increase four times faster than the population of those under 65.

In 1978, the average per capita expenditure for health care by individuals who were Medicare eligible was $2,026. The significance of this figure is illustrated by the fact that per capita spending for individuals between the ages of 19 and 64 totalled $764, for individuals under 19 the figure was $286, and the average for the combined group was $753. The statistics also indicate that individuals over the age of 65 are more likely to be hospitalized than those under that age, they use more hospital days per hospitalization, and they visit their physician more frequently. The importance of these figures is clear: as the population ages, demands for health care dollars will correspondingly increase.

Inflation

The most substantial element in the growth in expenditures for health care from the period of 1971 to 1981 has been the general inflation besetting the economy. According to an article published in the March 1983 issue of Health Care Financing Review, general inflation "accounted for approximately 57% of the increase in total systems costs (personal health care costs) for the period 1971 to 1981." In addition, approximately 8% of the growth in expenditures is directly attributable to the aggregate population growth over that period of time.

Resource Allocation

The United States may have reached a point in its history where sustained economic growth can no longer be maintained and limited resources will force the necessity of facing difficult choices. As witnessed by the total revamping of the methodology for payment for hospital services under Medicare, this Congress has established its willingness to reduce resources devoted to health care. However, we urge caution so that changes made today do not place in jeopardy the continued availability of quality health care for future generations. If this Committee elects to look for a means by which all health care expenditures will be constrained, numerous questions will have to be addressed:

- What should be the priorities by which funds are allocated among basic research, applied research, the education of health care professionals (including physicians), the maintenance of health care facilities and delivery systems, and the actual delivery of health care services?
- High technology makes possible the treatment of certain afflictions but at a tremendous per capita cost. Which should have greater priority: heart transplants for the middle aged and the Medicare population, or expanded immunization programs for children?

- Are governmental and private insurance programs covering too much for too many and thereby destroying incentives that encourage individuals to take responsibility for personal health?
- Are individuals inappropriately insulated from the actual cost of the care they receive?
- What is the most beneficial mix of primary care physicians, physicians in specialized practice, and other health care delivery personnel?

These types of questions must be considered whenever an action is undertaken to limit the expenditures for health care services in the United States. Efforts to moderate the growth of expenditures for health care services also must be viewed with an eye toward the future impact on the availability of quality health care services.

The medical profession is dedicated to the provision of the best possible care available to patients in need of care. In the past, this dedication has run up against ethical considerations based on the availability of resources necessary for the provision of optimal care. A classic example of this dilemma that was finally resolved through the legislative process is the development of the end-stage renal disease (ESRD) program.

Prior to the enactment of the ESRD program, decisions to provide dialysis services often revolved around the availability of such services, as there were shortages in renal disease equipment, trained personnel and treatment facilities. Decisions as to who would be availed the opportunity of treatment were being made by ad hoc committees. These committees, by necessity, made life and death decisions. Such committees became unnecessary in 1972 when Congress provided coverage under Medicare for people suffering from chronic renal disease.

The effect of this decision by Congress was the expansion of a specific medical technology to all of those in need of it, but at a substantial cost to the federal government. In 1974 when the program was initiated, it covered approximately 18,400 individuals at a cost of about $230 million. Presently, the program serves over 70,000 patients at an annual budget of almost $2 billion.

Mr. Chairman, while there is little disagreement over the fact that the ESRD program is an expensive one (renal patients represent approximately 1/4 of 1% of the Medicare beneficiaries, but they consume nearly 10% of the Medicare Part B budget), it is extremely doubtful that individual program beneficiaries, their families and friends would object to the program's expense. Nevertheless, it is just such expenses and such programs that illustrate the considerations that are inherent in decisions made in the name of health care cost containment. By way of example, these questions relating to individuals with a need for dialysis were decided differently in the United Kingdom where age is a primary consideration in determining eligibility for dialysis treatment. According to an article in the March 1983 issue of Health Care Financing Review, "35 percent of British dialysis centers had a policy to exclude patients over 55, and 80 percent excluded patients over 65."

While members of this Committee may believe that cost should not be a determining factor in establishing health care coverage, programs similar to the ESRD program and coverage for the delivery of expensive medical technology are likely to present difficult decisions. This fact is illustrated by the recent policy recommendation issued by the Advisory

Council on Social Security: "The Council opposes any further extension of Medicare coverage to individuals (not otherwise eligible based on age or disability status) on the basis of medical diagnosis or the medical necessity for a particular form of treatment." The difficult nature of such disease-related treatment is illustrated by the fact that the Council does not want the Medicare program to be responsible for the provision of such coverage. At the same time, that Council indicates that if such a decision is made to cover a specific category of disease with federal financial assistance, such assistance should be provided through a separate special program.

AMA Cost Effectiveness Activities

While the medical community recognizes that it is not in a position singlehandedly to curtail inflation or population growth, we looked at the remaining reasons for the increase in health care expenditures and we are taking positive action to eliminate inappropriate expenditures.

The American Medical Association has taken an active role in issues relating to the cost of health care. The AMA was instrumental in the development and operation of the National Commission on the Cost of Medical Care, and has been working to implement recommendations (attached as Appendix I) from this Commission relating to strengthening price consciousness, private sector cost containment initiatives, working through the regulatory process, cost containment measures within medical practice, issues relating to supply and distribution of health care providers, research guidelines, and consumer and patient information. An important element of this Commission's report emphasized the importance of changing incentives within the health care delivery system to enhance competition. The 48 recommendations of the Commission on the Cost of Medical Care, issued in 1978, have served as a starting point for AMA activity related to cost-effectiveness.

For the past three years, the AMA has published an annual Cost Effectiveness Plan. The 1983 Plan documents the Association's on-going efforts to stem inappropriate growth of medical care costs. (A copy of the cost effectiveness plan, AMA Cost Effectiveness Plan: 1983 and Beyond, is attached to this Statement as Appendix II.) This Plan details numerous activities of the AMA to meet its commitments concerning limiting health care costs that are found to be inappropriate.

One of the more promising activities that the AMA is involved in concerning cost effectiveness is the newly formulated cost effectiveness network. This network is co-sponsored by the AMA, the American Hospital Association, and the Federation of American Hospitals and is aimed at involving hospital medical staff and administrators in collaborative cost effectiveness activities. The program consists of more than 80 hospitals throughout the country that will take part in experiments to evaluate a variety of cost effectiveness projects.

The first project to be implemented within this network is a protocal for holding economic grand rounds. The purpose of this program is to enhance physician awareness of the cost of the services they order by use of the grand rounds teaching forum. This program has essentially four operational goals:

- to encourage practicing physicians to reflect on their practice patterns in the context of cost effectiveness issues;

- to reinforce clinical behavior which is directed toward the cost effective delivery of high quality medical care;
- to change physician behavior where appropriate to reflect more cost effective delivery of high quality care;
- to stimulate additional subsequent activities geared to foster the cost effective delivery of medical care.

If this program and other programs developed through the cost effectiveness network proves beneficial, it is hoped that similar programs can be launched in other hospitals and that a major impact will be felt throughout the health care delivery system. (The following document is attached as Appendix III: AMA Cost Effectiveness Evaluation Network: Economic Grand Rounds.)

The American Medical Association fully recognizes that an important element in the growth of cost effectiveness activities is the publication of information about on-going efforts to deliver cost effective health care. To this end, the AMA is in its second year of publishing the AMA Cost Effectiveness Bulletin. This Bulletin is designed to provide cost effectiveness information to state medical associations, metropolitan and county medical societies, and national medical specialty societies. In addition this Bulletin is generally available to hospitals, hospital associations, and other interested parties. The Bulletin publicizes information on AMA cost effectiveness activities and also publishes information related to the activities of other organized groups working to this end. (A copy of the May 1983 AMA Cost Effectiveness Bulletin is attached as Appendix IV.)

The AMA has recognized the fact that medicine by itself cannot act to hold down rising health care costs. For this reason, the AMA started working with state and county medical societies in 1979 in the development of community-based health care coalitions. These coalitions work to bring together physicians, business and labor representatives, hospital management, and insurors to provide local forums to seek ways to contain costs while maintaining accessibility and high standards of heath care.

Health care coalitions have had success in such diverse activities as case management and utilization review, expanding physician and employer knowledge about employee limitations in particular work places, redesigning corporate benefits to encourage more cost effective ways to use the health care delivery system, increasing opportunities to develop the most cost effective and equitable forms of provider payments, drafting and supporting legislation to reform medical liability laws, developing health education programs in the workplace, collecting and analyzing data on utilization of services, and community health planning. (Attached as Appendix V is a document entitled The Minnesota and Philadelphia Stories. This document gives case histories of two health coalitions.)

The AMA has undertaken other activities to emphasize the importance of cost effectiveness. In 1982, the AMA cosponsored the National Conference on Utilization of Health Services with the American Hospital Association and the Blue Cross and Blue Shield Associations. This program focused on improving the efficient use of health services through early discharge programs, alternatives to inpatient care, and effective utilization review. Because of the success of this conference, the AMA has expanded its program on utilization of health services. The AMA also sponsors annual conferences, the National Medical Specialty Society Cost Effectiveness Conference, to aid medical specialty societies in the development of cost effectiveness projects that are geared to their own memberships.

The groundwork for cost effective medical practice must begin in medical school. To this end, a recommendation from the National Commission on the Cost of Medical Care was that medical, dental and osteopathic schools should expose students to the economics of the care they deliver. Since this recommendation was adopted by the AMA House of Delegates in 1978, most medical schools have integrated cost containment as an element of medical education. As of 1981, the subject of cost containment was taught in 93 of the 124 United States medical schools, and the issue was taught in almost every state.

In addition to stressing the value of cost effectiveness in medical education, the AMA is also stressing the value of prevention as a means to achieve cost effective health care delivery in this country. This very weekend, the AMA is sponsoring a national conference in Miami on the issue of prevention of disabling injury. The conference will concentrate on developing concensus definitions of injury and disability, prevention of injuries in various settings, and the physician's role in preventing disability due to alcohol-related problems.

Aside from these organized activities geared toward curtailing health care costs, the single most important means by which American physicians work to hold the line on health care costs is in the development of a physician/patient relationship. Through this relationship, physicians work to promote healthier life styles and to educate their patients to prevent disease and injury from occurring. Physicians have been leaders in anti-smoking campaigns and in educating the public on issues such as moderation in the use of alcohol, the use of child passenger restraints in automobiles, and drug abuse.

Health Policy Agenda

The American Medical Association realizes that Congress needs assistance from the public in making any future determinations on how health care services should be delivered in this country in the future. To this end, the American Medical Association has taken the first step by initiating a project to create a future health policy agenda for the American people. This project is designed to develop a philosophical and conceptual framework as the basis for specific action plans and proposals that are to be responsive to the particular social, economic, scientific, educational and political circumstances facing health care decisions. To develop a series of principles and action plans, six work groups have been organized to develop principles and action plans in the following areas: medical science, health care education, health resources, health care delivery mechanisms, evaluation and assessment, and payment for health care services.

The first phase of this project, the development of principles, is scheduled to be completed this summer, and the work groups will then spend the next year in developing action plans to carry out the principles. This activity involves approximately 150 organizations including representatives of medicine, government, nursing, labor, business, the hospital industry, the public, and health care insurors. By this broad-based organizational body, we hope to be able to present Congress with viable principles and working programs for the development of a future health policy agenda that will assure the availability of high quality health care services for the American people.

The AMA expects that the Health Policy Agenda project will look to the cost of providing health care services, and we expect that this body will come to grips with the same questions we have presented to you today.

Conclusion

Mr. Chairman, the American Medical Association realizes that the deliberations of this Committee and Congress concerning the future allocation of dollars for health care will have an impact on the delivery of health care in the future. Future societal decisions concerning how many health care dollars there will be and how they are to be directed are as much life and death decisions as any decision that a physician may face in the course of his or her practice.

At this time, Mr. Chairman, I would be pleased to respond to any questions that you or other members of the Committee may have.

0890p

QUESTIONS FOR DR. BOYLE AMERICAN MEDICAL ASSOCIATION

1. THE AMA HAS A LONG-STANDING POLICY IN OPPOSITION TO THE FEDERAL HEALTH PLANNING PROGRAM. WOULD YOU EXPAND ON THIS POSITION?

2. IT IS ACKNOWLEDGED THAT DOCTORS ARE COLLECTIVELY THE HIGHEST PAID PROFESSIONALS IN THE UNITED STATES. GIVEN THE GROWING PUBLIC CONCERN ABOUT HEALTH CARE COSTS, WOULD PHYSICIAN'S VOLUNTARILY ACCEPT LOWER INCOMES AS PART OF OUR OVERALL EFFORTS TO REDUCE THE COSTS OF HEALTH CARE, AND IS THERE AN ACCEPTABLE MECHANISM FOR ACCOMPLISHING THIS?

3. WE ARE SPENDING INCREASING AMOUNTS OF MONEY ON HEALTH CARE. WHAT ARE WE GETTING FOR OUR MONEY IN TERMS OF IMPROVED HEALTH STATUS FOR OUR COUNTRY?

4. COMPETITION HAS BEEN DISCUSSED AS A MEANS FOR REDUCING HEALTH CARE COSTS. COULD YOU EXPLAIN WHAT AMA IS DOING TO FOSTER COMPETITION AND HOW THIS WILL IMPACT ON FUTURE HEALTH CARE DELIVERY?

5. I HAVE READ RECENTLY THAT WITH THE HIGH RATES OF UNEMPLOYMENT, A NUMBER OF ORGANIZED EFFORTS ARE UNDERWAY

BY PHYSICIAN GROUPS TO PROVIDE FREE CARE TO THE UNEMPLOYED. COULD YOU EXPAND ON THIS ACTIVITY AND ALSO DISCUSS AMA'S POSITION ON HEALTH INSURANCE FOR THE UNEMPLOYED?

(NOTE: Responses to the above questions had not been received by the Committee by press time of the hearing.)

The **Chairman**. Mr. Bromberg.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, CHEVY CHASE, MD.

Mr. **Bromberg**. Thank you, Mr. Chairman.

We will submit for the record our statement. I would like to briefly summarize it, and then devote the rest of 5 minutes, if I may, to a response to some comments made this morning by Senator Metzenbaum.

I have tried to divide our testimony into three parts: first, an analysis of why costs are rising; second, an analysis of the marketplace solutions; and, third, an analysis of the regulatory solutions.

Being very brief on each, I would simply say, with respect to the analysis of why costs are up—and I compliment the committee on making that the opening subject because too often we go right to hearings on the proposals to solve it and we do not analyze the problem.

I would make two points. On page 2 of our testimony is a small chart that I think says a lot. It says that over the past decade, but particularly looking at last year, there was a 4.1-percent increase in hospital admissions of people over age 65, last year, while at the very same time there was a 1.6-percent drop in the number of people under age 65 admitted to the hospital. That, I think, says it best in terms of what the issue of demand is.

We have a growing aged population. People over age 85 happen to be growing at a rate faster than any other segment of the population. One out of every two of those people is hospitalized every year over the age of 85, and there is no way to stop that without rationing health care and denying quality of care to those people.

Second, technology has played a major role in it. The issue of technology—it is often looked at with examples of overbuilding and things like that, or one bill is picked out of 30 million admissions, as was done this morning, or with two visits to the tennis courts two bills were picked out of 30 million, but nobody talks about the other 29 million or 29.9 million. They say some things, too.

For example, they say that over the past 10 years the number of people who died in hospitals dropped from 3.1 per hundred to 2.5; that the number of people in hospitals who died of heart attacks dropped from 25 to 19 out of a hundred; pneumonia, 6 to 5.5; diabetes, 4 to 1; and malignant neoplasms, 16 to 12. Those are dramatic numbers that speak in terms of lives saved.

I might add, in terms of the earlier testimony from the manufacturing industry, I want to make it very clear that profits saved those lives, because it is profits that went into building those hospitals, even if they were surpluses in nonprofit institutions, or manufacturing investment that made the equipment to save those lives.

You can actually walk into a neonatal intensive care unit and count the number of babies whose lives were saved in a community after versus prior to that little 20-bed unit being built. That unit was built with profits or surpluses. Had we had cost controls over the past decade, a specified number of those units would not have been built and lives would not have been saved.

In terms of the marketplace approach, I think a lot has been said. I would like to make one suggestion or proposal. We have heard a lot about cost sharing and means testing. I think that is a critical part of this. One way to make a little more palatable what has to be done, which is cost sharing, might be to reduce or eliminate the medicare deductible, which has risen to $305 and it is going to $350. It certainly does not prevent or restrain utilization the way a daily copayment would based on a means test.

In terms of the regulatory approach, at the end of our testimony we try to analyze some of the approaches. On pages 19 and 20, at the conclusion, we look at some of which have already been discussed this morning.

It is very easy to save health dollars and cut costs. All you have to do is not give the service. That is the theory in Europe that says, if we do not treat those people, we will save money—very clear. It is what is happening in New York. If we do not make capital expenditures, we will save money, but hospitals are operating in a deficit, and the day of reckoning is going to come and it is going to cost more money.

These are supply side controls—certificate of need, rate regulation. They have not worked. Study after study shows they have not worked. What we need to do is what this hearing is supposed to be about—analyze the cause and, if it is, as we think, demand, technology, aging, increasing admissions, people desensitized to the cost who want more and more because they think it is free, because the Government has told them it is free with a tax subsidy of $25 billion, which if capped at the administration's level could save $31 billion over the next 5 years, money which could be used to save that medicare trust fund or subsidize care for the poor and the unemployed and high-risk patients—that is the problem.

In conclusion, let me just make one or two quick points. I have already responded to one. Two other points came up this morning.

Senator Metzenbaum made a statement that medicare-paid capital costs have doubled to investor-owned versus nonprofit. Just for the record, that takes medicare in isolation and totally ignores the tax laws, which are very relevant, becoming more and more relevant.

If you take the tax subsidy to nonprofit hospitals through tax-exempt bond financing and/or you add back the taxes our industry pays to the Government, you will find that it is almost identical, the subsidy to investor-owned versus nonprofit hospitals. It is just unfair to leave that standing unanswered.

The return on equity to this industry, it is the same thing. It has been reduced. It has come down $100 million without legislation because interest rates have come down, and it is tied to it.

The profit margin of my industry is 4.4 percent. I point out that CBS television, which Senator Metzenbaum quoted, their profit margin last year was higher. The profit margin, called surplus, of all the nonprofit hospitals in this country that got tax-exempt financing last year was 5 percent. We are proud of our profit margin because we think it is used—90 percent of it gets used back in the business to improve quality, and only about 10 percent gets distributed as dividends.

The last point I would like to make is that Senator Metzenbaum made a statement that is very important. He said that we are not a competitive industry the way others are and, therefore, we should be regulated. That is the whole point. We want to try to make it a more competitive industry through tax caps, vouchers, cost sharing, preferred provider plans, and a whole host of other things other than more Government intrusion. It was that Government intrusion that fueled the inflation, with good motivations but with bad legislation.

An example of that is when Senator Quayle says we are going to have to do some unpleasant things, he is right. The reason we are going to have to do some unpleasant things is because promises were made by politicians 17 years ago, and now the bill is due and they do not want to pay for it. They promised more care to more people without a means test, with dignity, because not enough people were getting care, especially the elderly and the poor. And, boy, we've delivered on that promise and we've met our share of it. Now we have to restrain it, and it is always unpleasant to go back on what seemed like an open-ended promise that health care was free. Now we know it was not free.

We also are beginning to find out that it is easy to politicize it. Senator Kennedy said this morning it is not a partisan issue. Well, it may not be, but it is certainly one that is easy to politicize when you can pick out a couple of hospital bills here and there and call for controls and try to avoid the real question, which is raise taxes or cut benefits or restructure, or all three.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Bromberg along with responses to questions asked by Senator Hatch follow:]

STATEMENT OF

MICHAEL D. BROMBERG

EXECUTIVE DIRECTOR

FEDERATION OF AMERICAN HOSPITALS

BEFORE THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

ON

MECHANISMS TO SOLVE HEALTH CARE COST INFLATION

MAY 19, 1983

Mr. Chairman and Members of the Committee, my name is Michael D. Bromberg, Executive Director of the Federation of American Hospitals.

The Federation of American Hospitals is the national association of investor-owned hospitals and hospital management companies, representing 1,045 hospitals with over 120,000 beds in the U.S. alone. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent more than 20 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to appear before you to present our views on health care costs. These hearings come at a very important and appropriate time. Congress has just enacted the most significant change in Medicare hospital reimbursement since the inception of the Medicare program by establishing a prospective payment system. Although prospective payment is an important first step,it alone will not solve the problem of health care inflation, and the impending insolvency of the Medicare Trust Fund.

Increased Demand

Because the proportion of the population over 65 will increase markedly over the next decade, the utilization of health care services per capita is expected to increase dramatically. Medicare expenditures, even after being adjusted for inflation, are expected to increase by 60 percent over the next five years.

Among the major contributing factors to hospital cost increases are admissions and intensity. The cost of treating over age 65 patients generally is more than two times the cost of treating patients under age 65 in hospitals. The following chart illustrates the admission intensity trend:

	Percentage Increase in Admissions				
	1978	1979	1980	1981	1982
Under age 65	1.0	1.7	1.5	0.0	-1.6
Age 65 and older	4.9	5.3	6.7	3.0	4.1

The intensity area also includes technological advances which save and prolong lives and are costly. There are many social, ethical and economic questions which can be raised in this area, but an aging society requires more intensive health care.

During the past twelve months admissions of over age 65 patients rose more than four percent while the rate of under age 65 admissions declined. Demand is the single most serious aspect of hospital cost increases and until demand is addressed, there will be no solution to health care inflation.

The government's commitment to the elderly, however, needs to be restated in terms which assure the elderly that their health benefits will be paid from a financially stable trust fund. It should also be made very clear to beneficiaries and providers that the government's commitment to pay for covered services does not mean there is no budgetary limit on the quantity of services that may be consumed. Until we address this issue, there will be no real solution to the increasing pressures on the Medicare Trust Fund. Benefit restructuring to revise beneficiary copayments and require a voucher option are two essential elements of any set of reforms designed to restrain utilization of services.

A Market Strategy

The large body of studies examing the cause of health care expenditure growth all point to the same conclusion: the problem is not inefficiency but utilization -- patients, freed from the burden of payment, demand more; and physicians and hospitals, unrestrained by cost-based reimbursement, provide more.

Our present system of health care financing has desensitized providers and consumers to the true cost of health care through the extensive use of first dollar coverage and low copayment rates. The situation has been aggravated by cost reimbursement which encourages excessive spending. The result is intense quality competition but little price competition.

Restoring cost consciousness to providers and consumers is intrinsic to any solution to rising health costs. Without price awareness, demand for health services is infinite. That is why we urge you to recommend solutions which address the demand side of the problem.

This Administration, like others before it, recognized that cost reimbursement has fueled health expenditure increases and needed to be replaced. Congress agreed and recently enacted a system which turns around the incentives in order to reward management efficiency and restrain utilization. We were supportive of the Medicare DRG pricing which becomes effective on October 1. However, that one long overdue change will not solve the health cost problem. We urge you to accelerate efforts to bring marketplace competition and restraints on utilization to the system by recommending the following legislative proposals:

(1) Benefit redesign to reduce the Medicare deductible and require reasonable cost sharing by Medicare beneficiaries during the first 30 to 60 days of a

hospital stay in order to encourage restraint in utilization;

(2) A voluntary Medicare private insurance option; and

(3) A ceiling on tax-free employer purchased health benefits, designed to encourage the offering of cost effective insurance plans.

These three changes would address the underlying problems in the current system and would alleviate the need for arbitrary cuts in the Medicare program. Enactment of a ceiling on tax-free health benefits and passage of Medicare benefit redesign with restructuring of cost sharing would also produce immediate budget savings.

Cost Sharing

The Congressional Budget Office has estimated that ten percent cost sharing from the second day through the 30th day would save over one billion dollars in the first year.

More important than the direct savings from sharing costs is the impact that consumer participation would have to deter excessive utilization.

A large body of economic analysis strongly supports the conclusion that financial incentives have a significant impact on utilization. Utilization goes down as cost sharing goes up. Here is a typical finding:

> "...when compared with full coverage, a 25 percent copayment reduces utilization and expenditures by 20 percent." (Charles E. Phelps, "Health Care Costs, The Consequences of Increased Cost Sharing," Rand Corporation, Santa Monica, California, November 1982.)

Congress, upon enactment of Medicare and Medicaid eighteen years ago and until quite recently, perceived its role to be one of increasing and assuring access for the elderly and the disadvantaged to quality health care. That public policy decision, combined with a cost based reimbursement mechanism which rewards spending and penalizes efficiency, triggered the demand-pull inflation contributing to the inflation in the health care expenditures. The recently enacted Medicare prospective pricing system is a long overdue step to correct the disincentives of that federal program.

The hospital industry has simultaneously been hit with severe cost-push inflationary pressuresfor the past ten years. Those major pressures included catch-up wages in a labor intensive industry; escalation of prices for the goods and services purchased by hospitals, particularly in food, fuel and malpractice insurance; rapidly changing medical technology in which new diagnostic and therapeutic techniques and expensive new equipment are centered in the hospital; inflated material costs for hospital modernization and expansion programs; increased capital cost; and increased cost of compliance with government regulations.

Many industries have faced similar cost-push inflation pressures, but none have experienced simultaneously the increased demand for services similar to that triggered with enactment of the Medicare and Medicaid programs using inflationary cost based retroactive reimbursement payments for hospital services.

Even without general inflation, federal and state health expenditures will still grow faster than tax revenues. For example, had there been no inflation over the period from 1977 through 1980, health expenditures would still have grown 14 percent in real terms. Of this amount, about 37 percent would have been due to population growth and 63 percent due to higher utilization per capita.

Since inflation can be dealt with effectively only by appropriate fiscal and monetary policy, health policy -- to have the maximum beneficial impact -- should focus on the next most important problem -- utilization.

The decisions regarding health policy boil down to who should benefit, who should choose, and on what basis the choices should be made. Ideally, the beneficiaries should be both the individual patient and society as a whole. The choice as to the use of health care services should be in the hands of patients and their physicians. And, the basis of choice should be a combination of the best health interests of patients and society's interest that the extra value provided by extra services equals or exceeds the extra cost.

The Federation of American Hospitals thinks that a ceiling on tax free premium contributions, a uniform employer contribution, and a Medicare voucher system would best strike the right balance between the patient's interest in getting good health care and society's interest that the value of health care benefits exceeds their associated costs.

Tax Policy

Current tax policies devised to stimulate certain behavior often prevent the efficient delivery of quality health care. Financing of health care through income exclusions and deductions often results in apparent misallocation of health resources, while other Internal Revenue Code provisions and regulations prevent arrangements leading to more efficient use of those resources.

Many view the exclusion from employees' income of the employer contribution for employees' health insurance as a major factor in rising health care expenditures. Several bills introduced in Congress deal directly with the employer contribution issue and focus on tax laws as a potential catalyst for health care system reform. Current tax subsidies, over $25 billion in value, fuel the demand for insurance, utilization and unrestrained spending in the health field.

Employer Contribution Exclusion

Presently, under Section 106 of the Internal Revenue Code, amounts contributed by employers for employees' health insurance are not included in the employee's income. This amount also is not included in the amount of the employee's pay which is subject to Social Security taxes. Consequently, employees have a great financial incentive to bargain for more costly, broad, employer financed health benefit packages. Since there is no limit on the amount of the exclusion, neither side -- labor nor management -- has any financial incentive to reduce health beenfits nor provide less than first dollar coverage. Employees are not encouraged to seek benefit packages more specifically tailored to meet their health care needs, especially in light of the prevalance of group health coverage. Such broad coverage stimulates more frequent utilization of health care services and drives up health care expenditures. It effectively eliminates any cost consciousness on the part of consumers of health care.

Enactment of a ceiling on the employer exclusion would cause many employers to voluntarily offer multiple health plans including a low cost option.

Eliminating the open ended employer contribution while encouraging equal contributions to all employee health insurance plans will stimulate competition among health plans and providers. Also, consumers of health care must have some financial stake in the system through some cost sharing of premiums and copayment of incurred costs in order to bring some market oriented restraint into decisions about utilization and choice of plans. Higher premium and delivery costs should be borne by the party selecting the plan or provider.

Consumer Choice for Medicare Beneficiaries: The Voucher Option

Medicare pays for about 16 percent of total personal health expenditures. Thus, any discussion about health system reform or consumer choice legislation is incomplete, and possibly irrelevant, without the inclusion of Medicare-Medicaid reforms.

A consumer choice approach allows consumers to shape the health care system according to their own preferences as directly revealed in their purchase decisions. Government, which can never know consumer preferences as well as consumers themselves, is no longer necessary as an intervening agent. This pro-competition strategy treats health care like other industries such as housing and food -- basic necessities of life which are essentially unregulated except for government programs to help the aged and disadvantaged.

A Voucher System

We support a Medicare voucher option as the financing vehicle for offering consumer choice to Medicare beneficiaries. A federal payment or voucher would, at the beneficiary's option, be used in the purchase of private health plans (traditional insurance or alternative health systems).

The initial voucher amount should be the average per capita expenditure for Medicare beneficiaries adjusted for age, sex, area and health status.

A voucher approach would in effect be a national experiment in consumer choice. The aged population would decide whether private plans are preferable to a government run system. A Medicare beneficiary would be entitled to have an annual election among qualified health plans or the existing Medicare program. If not satisfied, the beneficiary could choose another plan the following year. States could elect to participate in such a system for Medicaid eligibles as the system progressed.

Although the voucher system is new to health care financing, the basic idea is very familiar to the public. Dollar bills are vouchers. The only difference between a thousand dollar bill and a thousand dollar health insurance voucher is that the money can be exchanged for anything but the voucher only for health insurance.

Beneficiary Rights

The consumer choice approach for Medicare-Medicaid patients would produce major changes in the access and influence of the aged and poor in the health marketplace. By arming these patients with vouchers and private insurance or membership in health plans, the proposal will change the attitude of health providers toward these patients. Second class medicine in America is simply an economic term meaning patients for whom reduced payment and increased regulation are imposed on providers by government. The problem of physicians refusing to take Medicare assignment or refusing to see Medicaid patients and the "dumping" of Medicaid patients in public hospitals are the direct result of inadequate government reimbursement.

Under a voucher system these patients would be viewed as equal to all other privately insured consumers, increasing their access to quality health care and their influence over the system.

Budget Impact

From the government's perspective a voucher system means fixed premium payments in lieu of open-ended reimbursement. This should not only make government spending more predictable, but also it will reduce administrative costs. Also, the voucher system would help assure that government health care budgets provide beneficiaries with the best health care possible for the dollar -- much better than what they would receive under the status quo. This would happen because use of vouchers encourages innovation in health care delivery -- the best hope for better health care at less cost -- and forces providers to consider the patient's economic as well as health interests.

Provider Impact

A voucher system would impact health providers in several ways. Government regulation and disputes over reimbursement rules would be replaced by health plan negotiations for fixed payment rates. The prices of health providers would become more visible and subject to consumer pressure through their choice of health plans. Providers would be more accountable to the public and would have to justify pricing practices to consumers who would be sharing part of the costs involved in their care.

Impact on Insurance Industry and Health Plans

The insurance industry and health plans would be challenged to market private plans to the large segment of the population now covered by government. Innovative benefit packages would be designed to compete with the existing Medicare-Medicaid benefits. Outpatient drugs, home health care, unlimited hospitalization, and nursing home care are four examples of benefits which Medicare does not adequately cover for senior citizens. A plan which adds this kind of coverage might be more attractive to a beneficiary than existing Medicare coverage plus out of pocket payment for supplemental insurance.

Regulation

Some proponents of a broader regulatory approach support hospital state rate control programs as the answer to increasing health care expenditures. However, a review of state rate controls indicates little difference in expenditure growth on a per capita basis between the seven states with controls and all other states. 1981 per capita hospital costs rose 14.4 percent in rate control states compared to 17.5

percent in all other states -- no significant difference in 1981. Maryland also incurred per capita increases of 16.1 percent.

Hospital care is more expensive in states with mandatory rate setting programs. In 1981, per capita hospital expenditures for the seven states with mandatory programs were $426 versus $387 for non-mandatory states.

New York, which has the oldest and most advanced rate setting program, also has a hospital system which is in very poor financial health. From 1977 through 1981 New York voluntary hospitals have lost over $1.1 billion; 53 percent of the hospitals had losses in each of the five years.

Although New York has reduced its hospital expenditure growth rate more than any other mandatory rate setting state, the penalty is probably more than other states would be willing to bear. Liquidating a hospital system to save money is like demolishing the rooms of a house to cut energy costs.

This regulatory approach cannot be effective without sacrificing quality, eliminating innovation and competition, and we urge you to reject it.

Analysis of rate setting programs in the aggregate is quite misleading because individual state programs differ greatly both in design and effectiveness.

- The most up-to-date regression based analysis of the effects of individual state rate setting programs shows no statistically significant savings in hospital spending per capita except in New York and New Jersey. Regardless of the measure used (hospital expenditures per day, per admission, or per capita), the Maryland, Massachusetts, and Washington programs show no signs of having been effective. (Michael A. Morrisey, Frank A. Sloan, Samuel A. Mitchell, "State Rate Setting: An Analysis of Some Unresolved Issues," forthcoming in Health Affairs, Vol. 2, No. 2, Summer 1983, Hope Foundation, Millwood, Virginia.)

- The two states that did show significant savings from rate setting -- New York and New Jersey -- by no coincidence have enormous unmet needs for capital to renovate, replace, and modernize hospitals. New York's unmet capital need in the eighties is projected at $13 billion, New Jersey's at $4.9 billion. Together, these two states alone account for a third of the total national need. (Harold M. Ting and John D. Valiante, "Future Capital Needs of Community Hospitals," Health Affairs, Vol. 1, No. 3, Summer 1982, Hope Foundation, Millwood, Virginia.)

It must, however, be conceded that if a rate setting agency wants to squeeze hard enough, it can save money. Why not proceed?

Perhaps the most important reason is the issue of control. If a rate setting agency makes the decisions as to where cuts should be made, individual private sector organizations with different needs and different preferences don't. Further, an all-payors system would stifle the very dynamics of the market for health insurance that needs to be stimulated in order to achieve meaningful cost control. Specifically, under rate setting there is no innovation and no price competition, nor are these incentives for physicians and patients to restrain use.

Despite all its drawbacks, many commercial insurers and businesses support state rate setting because in their view it would "eliminate" something called a cost shift. A cost shift occurs when hospitals charge some patients more for the same service than they do others. Typically, people who pay hospital bills themselves or are insured by either a commercial insurance company or by an employer directly, pay more for the same service than Medicare or Medicaid beneficiaries. Simply put, through the cost shift, private patients subsidize public program beneficiaries.

People who promote the idea that state rate setting should be adopted to eliminate the cost shift, fail to understand that it is a hidden subsidy and its elimination is a false hope unless there is a commensurate cutback in services. If rate controls are not the answer, what is? The first step is incentives reform to encourage more judicious use of health services, especially hospitals, and greater productivity. The single most important change Congress should make is to put a cap on the amount of employer paid health insurance that is tax free to the employee. This tax subsidy is estimated by the Congressional Budget Office to exceed $25 billion as of 1983. By comparison, the federal government's share of projected Medicaid spending is only $21 billion. This open ended subsidy is ethically objectionable as well as bad policy.

As the Ethics Commission noted, "The employer-exclusion provision gives a larger subsidy to those with a smaller need for financial protection and exacerbates the tendency of lower-income people to be less well insured than those with higher incomes." The Commission goes on to say that "this pattern of care is difficult to justify from an ethical standpoint. There seems to be little reason for such government assistance to middle- and upper-income individuals, most of whom could take financial responsibility for their own care . . . without undue hardship." We heartily endorse this position and believe that on fairness grounds alone the tax cap should be applied forthwith.

Senator Kennedy's bill, S. 814, is a regulatory measure which relies on controlling the supply and providers of health services to contain costs. It is true that total costs can be contained by postponing services. The certificate of need regulations of the Federal Health Planning Act have postponed capital expenditures, for example, but they have done nothing to curtail the demand for new services. Rate controls have been enacted by about six states but have only significantly contained costs in New York where arbitrary controls have postponed needed capital spending. Finally, the ultimate regulation of supply in Great Britain and Canada has produced such long waiting lists for health services that many citizens die before reaching the top of the list for treatment.

These supply control techniques cannot work because patients and physicians believe they are entitled to an open ended amount of care paid for by some other party.

Demand side reforms address that very point by removing or limiting open ended subsidies, such as the exclusion from taxable income of all employer purchased health insurance. By stimulating price consciousness through tax reforms, cost sharing, and preferred provider contracting, demand side revisions use market forces to negotiate prices and penalize excessive capital spending. Certificate of need laws were enacted to restrain unnecessary expenditures made by providers who knew their costs would be reimbursed even if the facilities and services were underutilized. That has changed. Medicare prospective payment and private sector arrangements with price competitive providers will more effectively allocate capital resources than any federal bureaucracy could ever do.

For these reasons, we support the efforts of Chairman Hatch to encourage planning but not regulation through block grants to states.

We do not support the regulatory strategy of S. 814 because it fails to address the critical issue of demand. We believe it is time to limit federal tax subsidies for health insurance, impose reasonable cost sharing for federally financed services, and use the marketplace as a more effective regulator than government of health care costs.

Conclusion

One final note of caution. Prospective payment is a long overdue Medicare reform but it will not solve the problem of unrestrained demand for health services. If everyone is to be guaranteed unlimited health services, then cost control systems cannot solve the government's budgetary problems. If some limits on the amount of government financed health services are acceptable, then the question is how to allocate limited tax dollars.

We urge Congress to address broader health policy issues by bringing marketplace competition to and restraints on utilization of our health care system by enacting the following legislative proposals: a ceiling on tax-free employer purchased health benefits designed to encourage the offering of multiple insurance plans; benefit redesign to require reasonable cost sharing by Medicare beneficiaries during the first 30 or 60 days of a hospital stay up to a catastrophic level, in order to encourage restraint in utilization; and a voluntary Medicare private insurance option.

These changes, in conjunction with a Medicare hospital prospective payment system, will help achieve a rational health policy, dealing effectively with the underlying problems with our current system and alleviating the need for future drastic, arbitrary cuts in the Medicare program.

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QUESTIONS FOR MICHAEL BROMBERG

1. WE ARE SPENDING INCREASING AMOUNTS OF DOLLARS ON HEALTH CARE. WHAT ARE WE GETTING FOR OUR DOLLAR IN TERMS OF IMPROVED HEALTH STATUS FOR OUR COUNTRY?

2. COULD YOU MORE FULLY DESCRIBE HOW YOU THINK CAPITAL EXPENDITURES AND THE ALLOCATION OF RESOURCES SHOULD BE DEALT WITH UNDER A HEALTH CARE COST STRATEGY?

3. THERE ARE INDIVIDUALS WHO BELIEVE THAT FOR PROFIT HOSPTIALS HAVE A COMPETITIVE ADVANTAGE IN EXPANDING THEIR HOSPITAL SERVICES. WHAT IS THE CURRENT INCENTIVE FOR HOSPITALS TO RETAIN THEIR COMMUNITY BASED POSTURE?

Responses from Michael D. Bromberg

1. Advances in health care have significantly enhanced the quality of Americans' lives. Hospital lengths of stay for many conditions are shorter and the introduction by hospitals of new technology has helped lower patient death rates:

	Death Rates per 100 Hospital Discharges	
	1968	1978
All hospitalized patients	3.1	2.5
Acute Myocardial Infarction	25.1	19.1
Pneumonia	6.5	5.7
Diabetes	4.0	1.6
Malignant neoplasms	16.0	12.0

2. A competitive health care system will act to reduce costs. Hospitals operating efficiently in this environment will generate a surplus providing them access to capital either through their own surplus revenues or borrowed capital made available to institutions with favorable financial ratings. Those hospitals not operating efficiently will not do as well in the marketplace and will have less ability to generate capital. The marketplace will reward efficient providers and penalize inefficient providers.

3. Let me first emphasize that investor-owned hospitals are community based. Many non-profit hospitals have mirrored the practices of the investor-owned hospital industry by joining multi-hospital systems to achieve economies of scale through group purchasing. Use of corporate resources does not mean the loss of community-based decision making.

   Investor-owned hospitals are at a distinct competitive disadvantage in several ways. Non-profit hospitals are exempt from taxes, may receive charitable donations and direct federal grants, and have access to tax-exempt capital financing. Lenders to not-for-profit hospitals do not have to pay taxes on the interest they receive which lowers their borrowing costs. Investor-owned hospitals pay taxes and are not eligible for philanthropic gifts or tax-exempt financing.

The **Chairman**. Thank you.

Dr. Schaller.

STATEMENT OF DONALD F. SCHALLER, M.D., PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, PHOENIX, ARIZ., ACCOMPANIED BY CANDACE KELLER, LEGISLATIVE COUNSEL

Dr. **Schaller**. Thank you, Mr. Chairman.

I am Don Schaller. I am a family physician and I was a founder of a prepaid group practice in the Phoenix area some 12 years ago. I am also president of the Group Health Association of America. I am accompanied here today by Candace Keller, who is our legislative counsel.

I have submitted my formal remarks and I will not enlarge on those because they appropriately reflect the position of the Group Health Association of America. I would like to make a couple of additional points, however.

First of all, I would restate the dedication of the prepaid group practice plans of this country to quality care that is cost effective. I would also like to point out that it is important to understand that we in the prepaid health care field receive our income based on the number of enrollees we serve and not the number of services we provide. That statement says a lot about the nature of the incentives that exist in our field of medicine as well as the disincentives that occur to spend more or to utilize more.

The issue here today is obviously cost containment. If cost means the total dollars spent for health care, I think it is important to recognize that cost is a function of two multipliers. One is the unit price of the services that are provided by the profession and, two is the utilization level. If we are going to contain costs, we must not only look at what the unit price is, and whether it is appropriately charged, but we also must look at the utilization level and do what we can to reduce inappropriate utilization of all kinds of health services.

I feel that there are probably five factors that affect utilization of all health care services across this country today.

One factor is the demographic characteristics of the population served. We are all familiar with the utilization levels of medicare compared to a younger employed group. In our health plan, for example, the highest utilizing group of employees were our own employees. I think that says something about the familiarity of the health care worker with the system and his ability to obtain services when he feels it is appropriate.

A second factor is the physician practice patterns that weigh mightily on the level of services that are provided. You might look, for example, at physicians as purchasing agents that write the orders for perhaps 60 to 70 percent of all the dollars that are spent in the health care field. It is important to take a hard look at the way they practice and how they order the use of services.

A third factor is patient expectations. We have come in this country to believe that there is better living through chemistry and perhaps that more care is equated with better care. I do not believe those are quite true.

The fourth factor is the system barriers that may exist. I think, it is important for you in the committee to take a serious look at how they impact on the delivery of care. Barriers may include the copayments and deductibles that can keep a person from receiving care if they are too great. Barriers also might include a simple distance from an appropriate facility to provide the kind of care that is needed or a lack in the transportation system necessary to get individuals to the center at which they need to be seen.

The final factor that I think impacts on care is technology. I have heard about, and I am very familiar with, many of the magnificent devices that these gentlemen have produced, but I am also fearful that many physicians are not quite familiar with how they work. Every time a new machine comes on the block, everybody likes to run around and try it out to see if it works effectively. I think this sort of behavior adds to the total cost of care. Inappropriate use of these machines and devices must be examined, I think, very seriously.

If you will, I would like to propose to you a visualization of a graph. Consider that on the vertical axis, or the Y axis, of this graph is the outcome of care, and on the horizontal axis is the pure quantity of services that would be provided, whether it is the number of days in the hospital or number of shots of penicillin or the number of visits to a physician.

There is a level of attainment of health that can be reached without any professional services, given the fact that modern medicine is perhaps no more than 100 or 150 years old. Before that time, populations thrived. Then as services are added, such as an appendectomy for appendicitis or antibiotics for pneumonia, the outcome of care rises to a point where there begins a plateau of comparable outcome. Along this plateau, even though more services are provided, the outcome of health is no better. This horizontal plateau of comparable outcome goes to a point where iatrogenic disease may set in, and then the outcome of care may recede to some degree.

The point is that the value of utilization control features is to find out where doctors practice on that plateau of comparable outcomes, monitor the utilization patterns of their practice, try to find out why cost-effective physicians are cost effective, and try to find out why physicians who are not cost effective are not. Once you can identify those people, you can try to move the least cost-effective physicians back along the plateau of comparable care to a point that is less costly. Such action must be taken very carefully. It is important not to deny needed services because, when that occurs, the total outcome of care is infinitely more costly than it would have been if appropriate care had been given.

There is a place for well-crafted utilization monitoring and control features that try to do something about inappropriate utilization of health services. We feel that this kind of utilization is an inherent characteristic of the prepaid group practice plan and, therefore, should be a very important feature of any legislation that you might contemplate for the future.

[The prepared statement of Dr. Schaller along with respones to questions asked by Senator Hatch follow:]

STATEMENT OF

DONALD F. SCHALLER, M.D.
PRESIDENT
GROUP HEALTH ASSOCIATION OF AMERICA, INC.

BEFORE THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON
MECHANISMS TO SOLVE HEALTH CARE COST INFLATION

May 19, 1983
Washington, D.C.

Mr. Chairman and members of the Committee, I am Dr. Donald Schaller, President of Group Health Association of America (GHAA). The association represents over 100 prepaid group practice plans, a majority of the group and staff model health maintenance organizations (HMOs) in the country. GHAA's member plans serve in excess of 9 million enrollees, 80% of the total national HMO enrollment. I am a physician, and I was a founder of the Arizona Health Plan in Phoenix, Arizona, a for-profit, federally qualified HMO which began operations in 1973. The plan is now part of CIGNA Healthplan of Arizona, and I have most recently been Senior Vice President and Medical Director for CIGNA Healthplan's national operations which serve 700,000 members in five states.

I am pleased to be here today to discuss the role of HMOs as a cost effective influence in the health care marketplace. We, of course, share the widespread concern about the rapidly rising cost of health care. While we have never considered ourselves either the sole or the primary answer to the problem of health care cost inflation, we have demonstrated that we have a successful system for the efficient delivery of high quality care which has a positive impact on the communities in which we have become well-established.

Our growth in the past decade or more has been impressive. In 1970, there were only 26 HMOs in the country serving about 3 million members. Today, there are 269 HMOs serving in excess of 11 million members. The majority of HMOs are group or staff model plans. While non-profit HMOs continue to predominate, in the past couple of years we have begun to see an increasing number of national HMO development efforts by for-profit firms. Although the federal HMO program was a significant investor in HMOs and played an important part in making HMOs an accepted part of the health care system, it is important to note that the bulk of funding has come from the private sector. HMOs have succeeded not as a government program, but because they offer an effective alternative to the predominant fee-for-service system.

The increase in the number of HMOs and the solid growth in membership of both new and existing HMOs is no accident. By delivering care for a fixed prepayment through an organized direct service system, we create incentives to use health care resources in the most efficient and appropriate manner without sacrificing quality. Basic to our system is improved access to care. Our members receive a comprehensive range of services without the economic barriers to early treatment which are found in the fee-for-service sector. Prepaid group practices achieve major cost savings including hospital utilization rates which are significantly lower than comparable fee-for-service utilization -- and our mode of providing health care has an impact upon the rest of the health care community. Studies show that the development of a strong prepaid group practice often sparks creation of a competing IPA model HMO (sometimes sponsored by the local medical society) and that providers competing with HMOs are spurred to reduce costs by improving their own patterns of utilization. In Phoenix where HMO enrollment has now grown to in excess of 160,000, the fee-for-service community has become increasingly aware of the importance of appropriately allocating health care resources.

Focusing in more detail on the impact of our cost effective patterns of hospital utilization, such modes of practice within the context of an organized delivery system permit us to engage in a variety of creative arrangements with hospitals which are beneficial to the HMO, the hospitals and the community. In negotiating with hospitals, HMOs can take advantage of the volume of predictable business they can bring to the institution; prompt payment terms; reductions in bad debts resulting from comprehensiveness of coverage (i.e., no payments to collect from the patient) and guarantees of eligibility; and the benefit of progressive HMO efforts to reduce stays and contain costs such as pre-admission diagnostic testing and early discharge programs.

HMOs (those that do not own their own hospitals) employ various methods to reimburse participating hospitals, depending in part on the above factors. They may pay itemized charges or discounted charges; more typically they pay a more predictable and cost-based all-inclusive per diem rate; some HMOs contract with hospitals to pay for a given number of beds, whether fully utilized or not, providing the institution with guaranteed "occupancy" in consideration for a preferred rate; still other HMOs reimburse hospitals on a capitation basis, providing greater predictability of costs to the HMO and revenues to the hospital.

Regardless of the specific contractual arrangements, HMOs and hospitals cooperate in efforts to share services and optimize the utilization of resources. These can include arrangements to facilitate appropriate treatment of patients who present themselves in emergency rooms; hospitals' agreements to accept the HMO's pre-admission testing, utilization review and early discharge programs; and sharing of costly diagnostic and treatment services.

Clearly, HMOs provide an alternative and a challenge to the fee-for-service sector and traditional health coverages. As health care cost inflation continues to rise rapidly, hospitals and other providers have begun to explore a variety of means for organizing care in an effort to achieve some of the efficiencies produced by our system. The new structures are largely untested, and in contrast to our lengthy track record, it remains to be seen whether they will achieve their goal.

A measure of the impetus for this activity is coming from the employer community which has been awakening to the important impact it can have as a purchaser of health care services. Some employers are moving towards benefit packages with higher copayments and deductibles in an effort to hold down premium increases among traditional carriers. At the same time, HMOs are growing in their attractiveness because they have been able to maintain their comprehensive benefits, while achieving significantly lower premium increases than their competitors. For example, at GHAA recently, for the same benefit packages offered in the preceding year, the three HMOs offered to the association's employees had premium increases ranging from 16% to 19%, while the Blue Cross and Blue Shield rate increase was 38%. Further, in a fairly recent development, HMO premiums are often lower in absolute terms than those of other carriers despite the more comprehensive HMO benefits.

As a result of our success in controlling costs while maintaining comprehensive high quality care, we are today experiencing some of the strongest support we have ever seen from the employer community, and more employees are carefully considering the option of HMO coverage. The AFL-CIO Executive Committee this spring urged AFL-CIO affiliates "to help develop and expand prepaid group practice plans and other alternative delivery systems." IBM now offers 160 HMOs and is evaluating the cost effectiveness to the company of its HMO offerings. The Ford Motor Company has already examined the value of its HMO offerings, and last year estimated that with HMO premiums averaging 14% below other carriers, a $5 million savings would result. The company offers 27 HMOs which, prior to the last open enrollment period, had enrolled 8% of the eligible workforce. This March, Philip Caldwell, Chairman of the Board at Ford mailed an unprecedented letter to every Ford employee encouraging examination of the HMO options available. Caldwell pointed out that HMO enrollment among Ford workers has increased 60% during the last five years and stated "the HMO approach provides an efficient, top-notch health care plan, limits out-of-pocket expenses for participants and lowers the Company's health care costs." With this sort of support, Ford is expecting a health increase in HMO enrollment this year.

Chrysler has gone even farther in encouraging its employees to consider joining the HMO it offers in Detroit, Health Alliance Plan of Michigan (HAP). Recognizing that satisfied members are an HMO's best marketers, during this year's open enrollment period the company offered each worker who was then an HAP member a savings bond of up to $250 for each enrollment by a fellow worker who joined the HMO on the member's recommendation. A Chrysler brochure states, "Chrysler can offer this special enrollment incentive because of HAP's favorable premium rates."

In addition to the growing popularity of HMOs among employers and employees, a new Medicare reimbursement mechanism will in the near future make HMOs more available to Medicare beneficiaries, and demonstration projects being conducted by the Health Care Financing Administration (HCFA) suggest that we will also be attractive to the elderly. Under the new payment method (enacted in TEFRA, P.L. 97-248), Medicare will pay the HMO a rate set in advance at 95% of what would have been spent to provide the Medicare benefit package in the fee-for-service sector. To the extent that the HMO's costs are less, the beneficiary will receive additional benefits. For the first time, HMO Medicare members will receive the full benefits of HMO membership -- predictable, limited out of pocket expenditures; no worries about locating providers who are willing to accept assignment, no confusing paperwork, and more services for their (and Medicare's) health care dollars.

In summary, HMOs have demonstrated that through a prepaid organized delivery system offering comprehensive health care, a cost effective allocation of resources can be achieved without sacrificing quality. By affording an alternative to the fee-for-service system, we are a health element of competition in the health care marketplace which challenges others to match our achievements. We would urge that one effective means of promoting health care cost containment is to insure that HMOs and other alternative delivery systems continue to have an equitable opportunity to compete.

group Health association of america, inc.

July 11, 1983

Mr. James W. Powell, Editor
Senate Committee on Labor and
Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Powell:

Enclosed are the responses to the questions submitted for the record by Senator Orrin Hatch to Donald Schaller, M.D., President, Group Health Association of America, in connection with the hearing on health care costs conducted by the Senate Labor and Human Resources Committee on May 19.

Please contact me if you have questions or need further information.

Sincerely,

Candace Keller

Candace Keller
Legislative Counsel

CK/va

Enclosure

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QUESTIONS FOR DR. SCHALLER
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
FOR THE RECORD OF THE HEARING OF
MAY 19, 1983
ON HEALTH CARE COSTS

1. As of 1982, approximately 28 HMO's were faced with financial failure. Why do you think these HMO's failed? What can be done to prevent future failures of HMO's?

The HMO failures that have occurred to date have been the result of a variety of factors. Not least among these was a policy followed by the federal government several years ago of resolving any doubts about applicants for federal grant monies for HMO development in favor of the applicants. As some of the weaker projects encountered difficulties in their first crucial years of operation, several of them failed.

As part of the "Consolidated Technical Assistance Program" funded by the Office of Health Maintenance Organizations of which I was a part, we identified a series of management problems which frequently occurred in troubled plans. A few of these plans failed but others, with corrective action, have succeeded. Among the problems identifed were failure to understand the interrelationships among the components of the HMO (i.e. administrative and medical staffs); inability to recruit experienced managers; and failure to monitor the performance of the plan and correct inadequacies.

It is important to note that with the critical period for the weaker federally assisted projects behind us, HMO failures have become rarer, and the HMO industry as a whole is showing inpressive stability.

At this time, solvency standards for federally qualified HMOs and related requirements for the protection of HMO members in the event of insolvency appear to afford adequate safeguards where problems do occur. In addition, in December, 1981, the National Association of Insurance Commissioners approved a new solvency provision for its model HMO Act which has been adopted or is being considered by a number of states, and state regulation of HMOs is in general becoming more sophisticated.

2. In the past, salaries for doctors in HMO's were not competitive with fee-for-service doctors, could this factor result in lower quality of care for patients?

HMO salaries for doctors are and have been competitive with the fee-for-service sector. As a physician who started an HMO, my experience has been that there are a number of attractions that prepaid group practice holds for physicians in addition to comparable salaries; for example, minimal need for administrative recordkeeping, certainty of hours, appropriate patient loads, use of paraprofessionals and assurance that a patient's individual financial resources do not pose a barrier to prescribing the preferred course of treatment.

At my own plan, I developed a rigorous physician recruitment program designed to identify able physicians who would be suited to practicing in an organized health care delivery system which has both utilization control and quality assurance mechanisms. The physician's attitude and adaptibility to the system have been of greater concern than our ability of offer competitive salaries.

In short, doctors salaries have not been a factor in HMO quality of care, and studies have shown that quality of care in HMOs is equal or superior to that in the fee-for-service sector.

3. It is my understanding that approximately 7 percent of people are under the care of HMO's, given the fact that HMO's claim to be the best answer to reducing health care costs, why haven't more people joined HMO's?

As I indicated in my prepared remarks. "we [GHAA member plans] have never considered ourselves either the sole or the primary answer to the problem of health care cost inflation...." In addition, there are many geographic areas in which HMOs are not available. However, where prepaid group practices have become well-established, they have had a positive community-wide impact.

The market share achieved by HMOs as a young and growing segment of the health care marketplace is significant. HMOs offer an alternative to the predominant fee-for-service system. We do not represent that every American will one day be enrolled in an HMO, but we have do have evidence that, as competing carriers' premiums skyrocket, increasing numbers of individuals are examining their HMO options and selecting HMO coverage. The reason for our current growth is our ability to provide high quality comprehensive health care at competitive premiums which reflect our effectivness at cost containment.

We caution those who might picture us as the primary answer to the nation's rapidly rising health care costs, but we do believe that our track record makes us an important part of the answer.

The CHAIRMAN. Thank you, Dr. Schaller.

I am going to submit questions to each of you, detailed questions. We would like to have responses back as soon as you can for this record.

The CHAIRMAN. I think you have all added to this hearing today. We are very interested in what is going on.

Thank you so much for coming.

Our final panel represents some of the many other interests in the delivery of health care.

First is Mr. Robert L. Roberts, executive vice president of the Allstate Life Insurance Company. Accompanying Mr. Roberts is Mr. James A. Dorsch from the Health Institute Association of America.

Our final witness will be Mr. Bert Seidman, director of the Department of Social Security of the AFL-CIO.

We would like to thank you both for being with us today.

We will begin with you, Mr. Roberts. If you could limit your remarks to 5 minutes, I would appreciate it, because I should have been gone about ½ hour ago.

STATEMENT OF ROBERT L. ROBERTS, EXECUTIVE VICE PRESIDENT, ALLSTATE LIFE INSURANCE CO., REPRESENTING THE HEALTH INSURANCE ASSOCIATION OF AMERICA, NORTHBROOK, ILL., ACCOMPANIED BY JAMES A. DORSCH, WASHINGTON COUNSEL, HEALTH INSTITUTE ASSOCIATION OF AMERICA, AND MARTIN DICKLER, CHIEF ACTUARY, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. ROBERTS. Having attended the entire session, I can certainly understand that.

My name is Bob Roberts. I am executive vice president of the Allstate Life Insurance Co. With me is Jim Dorsch, who is the Washington counsel of the Health Insurance Association of America, and Martin Dickler, who is the chief actuary for the Health Insurance Association of America.

We are pleased that you are raising the issue of rising health costs immediately after the passage of H.R. 1900, the Social Security Amendments of 1983.

The change in payment basis under medicare would probably not have been proposed were it not for persistent, rapid increases in health care costs in recent years. These increases have the same effects on the insurance coverage purchased by employers for their employees, by individuals for themselves, and by the self-insured as they do on Government programs. As a result, health insurance premiums are increasing annually at rates which range from 20 to 40 percent, depending upon the size and location of the policyholder. These increases are ultimately shared by employers, employees, and consumers, and adversely affect the economic health of American industry and, most importantly, the ability to compete in world markets.

We applaud and commend the Congress for its recognition of qualified State programs as an alternative method of medicare payment under the Social Security Amendments of 1983. We urge you now to adopt positive incentives for States to develop their own qualified program for all patients.

One such incentive would be a medicaid reward for those States which enact qualified programs, similar to the reward in present law for States which had hospital cost-containment programs in place on July 1, 1981. A modest medicare reward would be most appropriate for those States which are moving ahead to help solve a national problem—health cost inflation.

We further urge the Congress to take the next step on the prospective pricing—to enact legislation extending a hospital prospective pricing system to all payers, not just medicare, to take effect 4 years after enactment in any State which has not enacted a qualified State program. Such legislation would give every State time to enact legislation suitable to its own particular needs, and yet guarantee that all our citizens get the protection they deserve. It would also provide a stimulus to those who believe our problems are best solved at the State level to move ahead and get the job done so there will be no need for a Federal all-payer program.

We understand, Mr. Chairman, that another cost-containment tool—health planning—will soon be before this committee. We support this concept and look forward to working with you on this subject.

On the other side of the cost-containment coin, the administration has asked Congress to levy a tax on employee health plans as part of its fiscal year 1984 legislative program. It has even proposed in testimony to the Senate Finance Committee on April 27 that the employee health tax, not yet enacted, be increased to finance grants to States for health insurance for the unemployed—this while insisting that the purpose of the tax is to contain rising health care costs and not to raise revenues.

The health insurance industry opposes this proposal as discriminatory, unfair, and one that will do nothing to stop health care cost inflation.

Mr. Chairman, all of those in the private sector who have the most to gain from effective hospital cost containment—the employers, the unions, the insurers, in essence, all of those in the private sector on the paying side of the equation—say the employee health tax will be ineffective in curbing rising costs and are opposed to its enactment.

The most sensible approach to keeping hospital costs under control is prospective payment reform that applies to all patients, not just medicare patients. A prospective all-patient system will force cost-saving incentives into the structure of hospital payments and operations and will have many times the impact of the band-aid approach of taxing workers' health insurance premiums.

We are beginning to see that effective payment systems now in place in four States that involve all payers, including medicare, can work. There is no reason why the Congress should try the untested theory of taxing health insurance premiums and every reason why it should not.

Again, HIAA and its member companies share this committee's concern over rising health costs. We appreciate the opportunity to present our views.

I will be pleased to respond to questions.

[The prepared statement of Mr. Roberts, along with responses to questions asked by Senator Hatch, follow:]

STATEMENT

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

on

HEALTH CARE COSTS

Presented by

ROBERT L. ROBERTS

Before the

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

May 19, 1983

My name is Robert L. Roberts. I am Executive Vice President of the Allstate Life Insurance Company. I am accompanied by James A. Dorsch, Washington Counsel, of the Health Insurance Association of America. The HIAA is a trade association of approximately 325 companies which together write over 85% of the country's commercial health insurance. We appear today on their behalf.

We are pleased that you are raising the issue of rising health costs immediately after the passage of H.R. 1900, the Social Security Amendments of 1983.

The recently enacted law serves as a good starting point for discussion of the issues. It changes Medicare's hospital payment from the present retrospective determination of incurred costs to a system of prospectively determined prices. We agree that this change in incentives is highly desirable. In fact, prospective payment may be our last chance for a competitive solution to rising hospital costs. However, the new prospective pricing system applies only to Medicare. Any system that does not apply to all patients will not produce the desired changes in hospital behavior.

The change in payment basis under Medicare would probably not have been proposed were it not for persistent, rapid increases in health care costs in recent years. These increases and their effects on government programs are just as applicable to the insurance coverage purchased by employers for their employees, by individuals for themselves, and by the self-insured. As a result, health insurance premiums are increasing annually at rates which range from 20% to 40% depending on the size and location of the business. These increases are ultimately shared by the employers, employees and consumers and adversely affect the health of American industry.

A prospective pricing system which applies only to Medicare will admittedly hold down Medicare outlays, but it could permit hospitals to shift to other payers an additional $6 billion from recent federal cutbacks. If the change to a prospective system provides the right incentives to hospitals to voluntarily control health care expenses, and we agree that it does, such a change is equally needed by those who are not eligible for Medicare.

The existence of cost shifting has become well-documented since our industry publicly identified the problem a couple of years ago. Cost shifting totalled $5.8 billion in 1982 and will rise to $7.9 billion in 1983. By 1985 we expect to have $11 to $12 billion shifted to non-government charge patients.

As a logical business practice, hospitals recoup reductions in Medicare and Medicaid reimbursement by inflating charges to private patients. Those who are insured face higher premiums. Those who are not - such as laid-off workers who have lost their insurance - are faced with a ruinous hidden tax exacted at a time when they are least able to pay - a tax on their already sky-rocketing hospital charges. Without government action on an all-payer system, all private patients remain vulnerable to an unprecedented and financially intolerable level of cost shifting.

In theory, prospective payment leads to cost containment because hospitals will work with physicians to voluntarily reduce length of stay and ancillary services. The incentive for such behavorial changes is profit; hospitals will finally be able to get more money for doing less. But hospitals say such changes take time and substantial effort. In practice, hospitals will find it far easier to cost shift than to cost contain.

We support federal legislation that effectively protects private patients from additional cost shifts. Such protection could take the form of a residual prospective payment system for all-payers. While such a system would provide cost containment incentives, it need not produce savings to the private sector in the short-run. Furthermore, an all-payer system would not necessarily require that all-payers initially pay the same price for each DRG. But discounts ought to be justified by savings to the hospital and be available to all patients. For example, discounts for prompt payment would be appropriate. Government patients in Maryland are an exception to this principle. While sharing in all costs to the hospital including uncompensated care, they receive an additional discount in order to stay within the aggregate federal cap required under the Medicare waiver.

I would like to shed some light on arguments against an all-payer system. The Administration says that we private insurers will piggyback on the Medicare DRG prices once we recognize that we are paying too much for hospital care. Mr. Chairman, we already know we are paying too much but we are unable to pay less under a combination of current federal policies that generate cost shifting while prohibiting joint negotiation by insurers. We are caught between the competitive forces in the insurance market and the failures in the non-competitive hospital industry. Current comprehensive benefit contracts with employers would prohibit us from limiting our payments to hospitals to the Medicare rate because hospitals would bill employees for the difference. Employers and employees have made a conscious decision to elect comprehensive medical benefits in 90% of our group business.

If, in the future, an individual insurance company only offered to sell plans which limit benefits to the Medicare DRG rates, employers would again exercise their option in the free market to buy comprehensive benefits from another insurance company. What if the federal government intervened in the competitive health insurance market and prohibited the selling of comprehensive medical benefits; would you then indirectly succeed in controlling hospital costs? No, hospitals would charge patients all that the market would bear above the indemnity amounts. Many hospitals would soon find their solvency threatened as bad debts mounted.

You may ask whether we negotiate with hospitals to accept less than their charges as full payment. Hospitals have agreed to such requests to voluntarily reduce their revenues only where an employer or insurer has sufficient volume to force acceptance. Some Blue Cross plans and the Rochester-employer coalition so dominate their local areas as to be successful in obtaining such volume discounts. For the vast majority of the country, however, neither the insurance company nor the employer has sufficient local volume to negotiate charges and thereby prevent cost shifting. To drive home the point, the Prudential, which is the single largest private health insurer in the country, has only 4% of the private health insurance market, and that is spread over 50 states. We are too dispersed to negotiate individually and we are prohibited by antitrust laws from negotiating jointly.

Experience validates our frustrations over cost shifting. Experience has also shown that second-opinion surgery, ambulatory benefits and other coverage designed to reduce utilization are successful but alone have limited impact. Finally, experience with State prospective payment systems clearly demonstrates their effectiveness in containing aggregate health care costs.

This is a developing area and no one yet can claim to have all the answers to the questions of a single hospital payment reform system. In fact, two of the oldest and most effective systems, the Maryland and New Jersey programs, operate quite differently. HHS recently granted waivers to New York and Massachusetts, two of the nation's high cost states. In both of these states, all parties with a direct stake in hospital payment change--providers, employers, unions and insurers--actively participated in designing a solution. Both are implementing approaches different from those in Maryland and New Jersey. We believe all of these different approaches will lower costs and produce useful comparisons.

The federal government's past role as a catalyst has helped encourage variety and innovation. We believe this is the prime role for the federal government, and should be continued. We applaud and commend the Congress for its recognition of qualified state programs as an alternative method of Medicare payment under the Social Security Amendments of 1983. We urge you now to adopt positive incentives to States to develop their own qualified programs for all patients.

One such incentive would be a Medicaid reward for those States which enact qualified programs similar to the reward in present law for States which had hospital cost containment programs in place on July 1, 1981. A modest Medicaid reward would be most appropriate for those States which are moving ahead to help solve a national problem-health cost inflation. It would be a fitting way to attack a national problem at the State level without a new Federal bureaucracy. It would be a fitting reward to those States which, by holding down rising health costs, are taking action to hold down the number of citizens forced into Medicaid and other public assistance programs by health care inflation. Such a proposal need not, in fact, should not, require the States to set-up hospital rate-setting commissions. It need not, and should not, require any particular type of program, rate-setting, DRG, or otherwise, as long as the State program meets the criteria set forth in the Social Security Amendments of 1983.

We further urge the Congress to take the next step on prospective pricing - to enact legislation extending a hospital prospective pricing system to all payers, not just Medicare, to take effect four years after enactment in any State which has not enacted a qualified State program. Such legislation would give every State time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve. It would also provide a stimulus to those who believe our problems are best solved at the State level to move ahead and get the job done so there will be no need for a Federal all-payer program.

We also recognize that any over-all solution to the problem of rising health costs requires a reconciliation of the vital interests of a number of important segments of our society. Therefore we continue to support the appointment of a Presidential Commission, upon which all of these interests, providers, insurers, employers, and unions, among others, can be represented and which can be charged with the constructive resolution of the conflicts which make this problem so intractable.

Mr. Chairman, the health insurance business shares your strong commitment to cost containment. There is more we would like to do ourselves. Nevertheless, we find that we must struggle under some formidable handicaps. The field on which we compete is strewn with regulatory and economic obstacles that significantly interfere both with our ability to serve our customers and with efforts to improve the efficiency of the health care financing and delivery system as a whole.

Put another way, what would the insurance industry like to do and what are the barriers to their doing it?

Let us first identify these handicaps, all of which are externally imposed upon us. Then we will return to a discussion of each of them. Unlike the noninsured plans with which we compete, we are subject to stringent state regulation. Our product design creativity is also stifled by a range of provider protection laws. Unlike our chief competitors in many instances, we pay state premium taxes and federal income taxes on the earnings on our reserves. In addition, the highly competitive nature of our business and the antitrust laws preclude us from collaborating effectively for cost containment purposes.

If the efficiency of our health care system is ever going to be improved through more meaningful patient participation, we must first make certain that the choices available to consumers are not economically biased because of governmental constraints. When individuals or employers choose a third party payment mechanism, the choice should be among realistic alternatives. This is not fully possible today.

What we would like to see is a "level playing field" for all third party payors, including Medicare and Medicaid. When Medicare pays less, private payors pay more--in effect constituting a hidden tax on non-government patients which amounted to almost $6 billion in 1982, will be $7.9 billion in 1983, and is expected to reach $11 to $12 billion by 1985.

We find that many individuals and employers are increasingly frustrated when they realize that a large and growing portion of their health care expenses is paying not for their own care--over which they have at least some control--but for care given to public patients. We estimate that 16 percent of the hospital expenses incurred by our policyholders is being paid for care rendered to Medicare and Medicaid patients.

This cost shift would severely impede the ability of private payors to compete with government programs under Medicare voucher system such as that proposed by the Administration.

We want Medicare to pay on the same basis as other payors. The provision in the recently-enacted Social Security Amendments providing for Medicare recognition of qualified state hospital payment programs is a major step in the right direction.

Another possibility would be to require Medicare-approved hospitals to allocate equally among all private patients that portion of their budgets not reimbursed by Medicare or Medicaid.

Second, as with the Medicare cost shift, state regulation does not apply evenly to various classes of payors. Employers that self-insure employee welfare benefit plans are exempted from state regulation by the preemption clause in Section 514(c) of ERISA. Such noninsured plans are not subject to the myriad legislative and regulatory requirements imposed upon insured plans. These requirements, which vary considerably from state to state, typically include a wide range of mandated benefits, free choice of provider provisions, and continuation of coverage and conversion options which are often quite costly. Employers may avoid these obligations as well as the necessity of maintaining reserves and paying premium taxes simply by not insuring their plans.

In order to nurture competition in the health care field, we should assure that all competitors are subject to the same rules.

Insurance laws and regulations serve a beneficial purpose in protecting the insured public. However, ERISA now precludes the states from regulating the affairs of noninsured health plans, but at the same time the federal government has failed to regulate these health plans.

The very fact that these plans are unregulated makes them increasingly attractive funding alternatives for employers. Indeed, as much as 50 percent of the new health-related business written by major insurers is no longer conventional health insurance. This is an obstacle to competition that we are not able to overcome without Congressional support.

It is also a very real impediment to innovative plan design by insurers.

We recommend that Congress require that state taxation and regulation apply equally to all funding mechanisms. We are not proposing a substitution of federal for state regulation. However, our business does support, for example, Section 3605(a)(ii)(I) of S. 1541 (the Retirement Income Incentives and Administrative Simplification Act, introduced by Senator Nickles) which would amend ERISA to preempt state mandated benefit laws for insured as well as for non-insured employee benefit plans. This simple change would be a first step along the way to more equitable competition and more rational benefit design.

We would like to set up programs in every state, as we have done in Connecticut, to guarantee the availability of health insurance to all individuals. However, again, ERISA is a major barrier to our seeking state laws setting up these programs. We feel strongly that all competitors in the employee health benefit market should share proportionately in any program losses. However, ERISA preempts state laws to the extent those laws require self-insured plans to participate in these state programs. Thus, self-insured plans are effectively shielded from the economic burden of the guaranteed availability programs, a burden which falls on an ever-decreasing base caused by existing legal barriers to equitable competition. The program could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools and requiring all employee health benefit plan funding mechanisms to participate in such a pool as a condition of income tax deductibility or by otherwise requiring self-insured employers to participate in such programs.

In a similar vein, there are any number of state laws enacted to protect the interests of different classes of providers. These laws often operate to prevent the establishment of preferred provider plans by insurers and stand in the way of negotiations between insurers and providers. They essentially preclude any insurer from restricting in any way any beneficiary's "freedom to choose" any health provider the insured wishes. An interesting experiment is beginning on this subject in California; and we should know before too long whether competition among providers will be enhanced by California's new law allowing an insurer to negotiate with providers. Note, the California law still does not allow more than one insurer to jointly negotiate.

Last, we would like to share data and engage in joint cost containment activities, such as negotiating with health providers, the development of physician profiles and patterns of care, and other such activities. Specifically:

1. Insurers should be authorized jointly to collect, analyze and use information on the quality, cost, or utilization of health care services, including the development of reasonable, or preferred utilization practices as guides for insurance reimbursements to providers. In other words, commercial insurers should be able to [illegible] together [illegible] data.

[illegible] also be empowered collectively to negotiate [illegible] to develop utilization standards. It should further be possible for insurers jointly to contract with review organizations to provide peer review and concurrent hospital review for private patients and to provide data to such organizations.

Employee Health Tax

On the other side of the cost containment coin, Mr. Chairman, the Administration has asked Congress to levy a tax on employee health plans as part of its F.Y. 1984 legislative program. It has even proposed, in testimony to the Senate Finance Committee on April 27, that the employee health tax, not yet enacted, be increased to finance grants to the states for health insurance for the unemployed, although insisting that the purpose of the tax is to contain rising health care costs, not raise revenue.

The health insurance industry opposes this proposal as discriminatory, unfair, and one that will do nothing to stop health-care-cost inflation, nor will it raise the revenue suggested as labor-management negotiations rearrange the employee benefit package.

Among the arguments against such a tax are the following:

- It penalizes older workers. Elderly groups tend to use health care more frequently than younger, healthier workers. Hence, the cost of health insurance for a group which includes more than the average number of older workers not only will be higher but could discourage many employers from hiring the older worker. Under the Administration proposal, these groups will be adversely affected by a cap, while younger groups with similar coverage may not be taxed.

- It penalizes those in hazardous, high-risk occupations. Some groups, such as iron workers or coal miners, are usually considered a higher "risk," and are typically charged higher health insurance premiums. These groups could be unfairly taxed while other groups with similar coverage--such as clerical workers--would be unaffected.

- It is a form of "double taxation." The Health Insurance Association of America estimates that Medicare and Medicaid payment practices resulted in $7.9 billion being shifted to patients covered by private health insurance in 1983 to make up for government underpayment to hospitals. For the government to shift these costs to the private sector and then put a tax on the resulting higher insurance premiums is patently unfair.

- It unfairly affects certain geographic areas. The cost of health care is higher in some areas, such as large metropolitan cities. A single national tax cap does not take geographic differences into account, and thus would particularly penalize those in high-cost areas. Conversely, it would allow the tax-free purchase of much more generous benefit plans by those in low-cost areas.

- It could result in reduced coverage for preventive care services. As employees scramble to reduce their overall premium rates, essential preventive care services such as dental care, vision care, mental health benefits, and alcohol and drug abuse servcies may be dropped from benefit plans. Dropping these benefits does nothing to reduce hospital costs, and in the end may have the opposite effect.

Mr. Chairman, all of those in the private sector who have the most to gain from effective hospital cost containment - the employers, the unions, the insurers - in essence, all of those in the private sector on the paying side of the equation - say the employee health tax will be ineffective in curbing rising costs and are opposed to its enactment. Those who have the most to gain by its failure to work, i.e., the health providers, say it will work to de-escalate hospital inflation. However, it is a fact that the medical expense people fear most is hospital expense, and it is hospitalization insurance that will be the last, and least, effected by this proposal.

The most sensible approach to keeping hospital costs under control is prospective pricing reform that applies to all patients, not just Medicare patients. Rising costs are not just a Medicare-Medicaid problem but a national health care problem as well. A prospective all-patients system will force cost-saving incentives into the structure of hospital payments and operations and will have many times the impact of the band-aid approach of taxing workers' health insurance premiums.

We are beginning to see that prospective payment systems that include all-payers, include Medicare, now in place in four states, can work. There is no reason why the Congress should try the untested theory of taxing health insurance premiums--and every reason why it should not.

Again, HIAA and its member companies share this Committee's concern over rising health costs. We appreciate the opportunity to present our views. I will be pleased to respond to questions.

**HEALTH
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Linda Jenckes
Vice President—Federal Affairs

July 5, 1983

Senator Orrin G. Hatch
Chairman, Committee on Labor
and Human Resources
U. S. Senate
Washington, D.C. 20510

Dear Senator Hatch:

Thank you for your gracious letter of June 13th. The Health Insurance Association of America is very appreciative of the opportunity to appear before your Committee on the subject of rising health care costs, a vexing problem which is of such concern to us all.

I have enclosed responses to the three additional questions which you sent with your letter. I hope they will be of assistance to you.

Best regards,

Linda

Linda Jenckes

cc: Members of Senate Labor
& Human Resources Committee

QUESTION NO. 1
WHAT HAS THE HEALTH INSURANCE ASSOCIATION OF AMERICA DONE TO REDUCE HEALTH CARE COSTS? COULD YOU TELL ME WHEN THESE ACTIVITIES BEGAN AND EXPLAIN THEM IN SOME DETAIL?

ANSWER:

THE PRIVATE HEALTH
INSURANCE BUSINESS
AND
HEALTH CARE COST CONTAINMENT:

A Report to the
Senate Labor and Human
Resources Committee

Health Insurance Association of America
1750 K Street, N.W.
Washington, D.C. 20006

June 26, 1983

INTRODUCTION

The nation's health insurance companies have a crucial stake in containing health care costs. They pay a large proportion of the hospital and medical bills of many millions of Americans. The more effectively insurance companies can control costs, the more competitively they can price their products for the public.

The health insurance business, accordingly, has strongly advocated, and in many areas pioneered, the development of cost containment measures. These have included:

- Improved benefit plan design
- More efficient claims administration
- Involvement in new types of delivery systems
- Aggressive support of a variety of other controls, including legislation at the Federal and state level
- Undertaking group policyholder and employee and public information programs, with a primary focus on cost containment and health promotion

Since 1956, the Health Insurance Association of America -- the official trade association of the commercial health insurance business -- has, through its staff and extensive committee structure, assisted member companies to carry out these activities toward improving the financing, delivery and quality of health care.

The Association has served as a forum for sharing experience and exchange of information on health care economics. It has provided technical and research support both to companies and to the providers of health care for programs to contain health care costs. It has channeled funds and manpower into private sector initiatives to bring about needed reform of the health care system. And it has communicated widely with all segments of the public on behalf of its member companies to focus attention on the problems and proposed solutions.

Hence, the health care cost containment programs of the Health Insurance Association of America and the more than 330 insurance companies it represents are closely intertwined and are the joint focus of this report.

IMPROVED BENEFIT PLAN DESIGN

Plan design is one of the major approaches to cost containment. In recent years more and more cost saving incentives are being incorporated into health insurance benefit plans. These incentives take many forms.

Patient Cost Sharing

Virtually from the beginning, insurance companies have encouraged prudent use of health services through patient cost sharing. Such arrangements include:

1. Deductible provisions, which require the patient to pay all initial costs up to a specified amount before the insurance becomes effective;

2. Co-insurance provisions, which require that the patient pay out-of-pocket a fixed percentage of each dollar spent for health care services; and

3. Copayment provisions, which require that a fixed sum, typically a small one, be paid prior to the rendering of any service.

These cost sharing devices give individuals a financial stake in assuring that the care they seek, or have prescribed for them, is both necessary and reasonably priced.

Second Opinions for Non-Emergency Surgery

Insurance company studies underscore the cost effectiveness of second surgical opinions. Accordingly, companies more and more reimburse for this practice.

A survey of large insurance companies in 1981 by the Health Insurance Association of America (HIAA) revealed that 75% of the 57 responding companies included payment of second surgical opinions compared with 14% ten years earlier.

A study in 1982 by the HIAA of 4,120 new or amended group health insurance contracts representing 492,219 employees showed that about three-fourths of the new contracts provide coverage for second opinions.

Outpatient Surgery

Reimbursement under many health insurance plans is provided for surgery performed on an outpatient basis. The above cited study of 57 large companies revealed that 96% of companies provided such a benefit in 1981, compared to 35% in 1971.

The HIAA study of new or amended group plans showed that 85% of employees had such benefits in 1982.

Pre-Admission Hospital Testing

By performing needed X-ray and lab tests on an outpatient basis prior to hospital admission, one or more days' hospital room and board charges can be saved.

Over a 10-year period, based on the HIAA study of 57 companies, the number covering pre-admission testing increased from 42% to 81% of the companies.

The HIAA new group survey revealed that coverage of pre-admission testing was included in 85% of the contracts in 1982.

Home Health Care and Skilled Nursing Facilities

Recognizing the cost saving potential of home care services as an alternative to a hospital stay, companies are offering home care as a reimbursable benefit.

The 57 company study reported 81% offering this benefit in 1981, compared with 5% in 1971.

Increasingly, too, there is reimbursement for skilled nursing facility services. In 1981, 89% of the companies in the HIAA study offered the benefit. Ten years earlier, 32% offered the benefit.

Preventive Care

According to a survey undertaken by the health and life insurance business in February, 1983, nearly one-third of the 150 responding insurance companies offer preventive care benefits under their group health insurance contracts.

The 57 company survey shows that 33% offered such a benefit in 1981, compared with 8% in 1971.

Among the preventive care benefits included in plans are well baby care, physical examinations, and preventive services under dental care and vision plans.

Other Cost-Saving Approaches

A variety of other innovative approaches to cost containment are being employed by insurance companies. These include:

- Flexible deductible and co-insurance provisions, such as first dollar coverage only on physician services, surgery center services and pre-admission testing, to encourage ambulatory and preventive care.

- Reimbursement for properly supervised paramedical services to improve physician productivity and lower costs without impairing quality.
- Exclusion of benefits for non-approved facilities, and unnecessary or obsolete treatment.
- One-hundred percent reimbursement of generic drugs instead of the usual 80-20% co-insurance if name brands are purchased.
- Paying for direct admission to a certified Extended Care Facility as an alternative to hospital confinement.
- Experimentation with hospice or terminal illness care.

CLAIMS ADMINISTRATION

Company Claims Control Programs

A number of insurance companies have joined together to improve claims processing -- and hence generate major cost savings -- through the use of modern computer networks hooked into hospital terminals to produce the electronic transmission of claims. This development reflects the increasing sophistication that computer technology has brought to claims administration.

Many companies have their own profiles of physician charges and are better able to identify cases of questionable treatment or high fees for referral to medical peer review.

Towards better claim cost control, companies have cooperated for many years with hospital utilization review programs, foundations for medical care, PSROs, and other physician organized programs. With respect to the health care foundations, in particular, a number of companies have helped to develop these management systems -- providing funds, manpower, and data -- in an effort to reduce hospital admissions or length of stay.

In addition, insurers conduct computerized analyses for group policyholders to pinpoint reasons for excess costs.

Increasingly, too, hospital bills are being audited by companies internally or by outside firms. An HIAA survey in 1983 of 40 member companies revealed that 32 of the 34 responding companies have audit programs in place. Typically the companies reported a 2:1 ratio of dollar savings to audit costs.

Insurance companies today almost uniformly apply the Coordination of Benefits (COB) provision to prevent policyholders from making a "profit" on illness. Under COB -- a principle worked out a number of years ago with the National Association of Insurance Commissioners -- an individual's health care benefits from duplicate plans do not exceed 100% of allowable medical expenses.

HIAA Initiatives

The HIAA, since its inception, has had as a major mission working with the providers of health care on programs to generate claim cost savings. Early in its existence the Association created a state network of insurance representatives to maintain direct contact with providers on problems of mutual concern.

In the 1960s the HIAA assisted in the establishment of medical society fee review programs in New York, California, Pennsylvania, Illinois, and elsewhere. The Association later worked with many groups to further hospital utilization review to examine the type and quality of care patients receive.

This activity reflected longtime industry support for the medical peer review concept. As a consequence, insurance companies endorsed the objectives of the Professional Standards Review Organizations (PSROs) created under the Social Security Amendments of 1972 to monitor physicians' services under Medicare and Medicaid. However, the health insurance business called for such peer evaluation to be extended to all patients, not just those under government programs.

Over the years, much effort has been directed to building effective data management systems. An industrywide surgical and dental charge data base has long been in existence. To assist member companies in responding to policyholder requests for detailed health cost containment information, the Association developed in 1982 an HIAA Hospital Inpatient Standard Data Set.

Member companies are being encouraged to develop the capability to begin collecting information on a prospective basis as of July 1983.

Over 25 years ago, as a means of reducing the cost of processing claims, the HIAA developed simplified uniform claim reporting forms for both hospitals and physicians. Today efforts continue to develop and implement national standards for hospital and physician claim forms, data sets, and coding classification systems.

ALTERNATIVE DELIVERY SYSTEMS

In the 1970s, a growing stress on alternatives to high-cost hospital services led insurance companies to experiment with the development of Health Maintenance Organizations (HMOs). As early as 1971, the HIAA, in testimony before the Subcommittee on Health of the Senate Labor and Public Welfare Committee, expressed the conviction that the HMO concept "can provide a significant contribution to the solution of the health care delivery and financing problems in the United States."

In 1972, the HIAA established an HMO Clearinghouse to facilitate the exchange of information among companies interested in HMO involvement. That same year the Association held a national conference for member companies to assess the potential role of insurance companies in these systems.

By the beginning of 1975 over 50 insurance companies were actively involved with more than 70 HMO projects, with some 23 of these operational. Over $60 million had been invested by companies in the form of grants, loans, and mortgage financing of operational HMOs.

A variety of roles have been assumed by insurance companies in HMO development and operation, including: financial support, consultation, administration, marketing, reinsurance, and providing hospitalization coverage.

In addition, in 1975 the health and life insurance business in conjunction with the Robert Wood Johnson Foundation launched a four-year program of investment in new hospital-sponsored primary care group practices. Under the program, some 60 hospitals across the country received Foundation grants totaling $30 million to establish group practices to provide primary care. As a result, these hospitals were eligible for approximately $45 million in long-term insurance company loans for construction and equipment costs.

Insurance company support has also been provided ambulatory surgery centers where minor surgery can be performed on an outpatient basis, thus significantly reducing the need for hospital beds.

ACTIVE SUPPORT OF OTHER EXTERNAL CONTROLS

The long history of support for health care cost containment includes vigorous advocacy of appropriate legislation at the

Federal and state level as well as a variety of voluntary initiatives.

Comprehensive Health Planning

In the late 1960s the HIAA created a Health Insurance Comprehensive Health Planning Action Program. A network of insurance representatives served on the boards of state and areawide health planning agencies reflecting the conviction of the Association that the health planning process was essential to elimination of unnecessary health care facilities and services.

The health insurance business was a strong advocate of The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) designed to assist states and communities in reviewing and planning their health care needs. Following its enactment, the HIAA testified in 1975 before the House Appropriations Subcommittee on Labor -- Health, Education, and Welfare to urge adequate funding to enable regional health planning agencies created under the Act to function in "their intended role of containing the escalation of health care costs and upgrading the quality of health care on a national basis."

The HIAA also gave strong support to "certificate of need" legislation at the state level to enable planning agencies to review and approve the need for services and facilities.

Insurance companies were -- and continue to be -- encouraged to contribute to the operating budgets of Health Systems Agencies, with substantial contributions resulting over the years. Also, insurance representatives continue to serve on the boards and advisory councils of these agencies.

Currently the HIAA continues to seek acceptance at the Federal, state and local levels of the Association's principles for continued government/private sector participation in health planning. Essentially these principles call for continuation of planning as a private and public sector partnership, with funding equally shared by both, and with full representation from all concerned constituencies.

Healthcare Program

In 1969, the HIAA approved a report entitled "Healthcare Delivery in the 1970s." This report served as the foundation for the "Healthcare Program for the 1970s" which was converted into the Burleson-McIntyre National Healthcare Act of 1971 and introduced into the 91st Congress. The Burleson-McIntyre Bill was subsequently reintroduced into three successive Congresses.

To spur Congressional and public support, insurance company representatives were organized in every state and a massive effort begun to press for enactment of this national health insurance bill which would have made maximum use of the private health insurance system and prudent use, where needed, of government resources.

Health care cost and quality controls were central features of the Burleson-McIntyre Bill and many of these have been embodied in subsequent legislation.

The Healthcare Program, for example, called for expanded financing of ambulatory care facilities with greater stress on prevention. It called for further strengthening comprehensive health planning, through reinforcing the role and responsibility of planning agencies. And it recommended prospective payment systems for all payers, as well as utilization review for every hospital.

A "Program to Contain Costs and Assure Quality"

Following extensive study, the HIAA in 1977 approved "A Program to Contain the Costs and Assure the Quality of Health Care in the United States." Representing official HIAA policy which the Association widely expounded, the program called for a wide variety of measures.

These measures included, among others, action to effectively implement the health planning law; promote pre-admission testing and alternatives to hospital care; initiate prospective budget review and peer review through PSROs for all patients; and permit insurers to jointly negotiate payment methods with physicians.

Hospital Payment Reform

As indicated above, the HIAA has long called for prospective payment for all payers. To this end, the Association has undertaken extensive efforts in several states in recent years to promote legislation creating state review commissions to set hospital rates prospectively For example, the Association was a major participant last year in a successful campaign to enact an all-payer prospective payment system in Massachusetts. It has also been active in efforts to achieve equity of payment for all payers in Pennsylvania, Illinois, Maine, Alabama, and other states.

Underlying these initiatives was a deep concern with the rapidly mounting problem of cost shifting from the public sector -- and in a number of states from Blue Cross -- to commercial insurers. Cost shifting was, and is, viewed as a major deterrent to cost containment because most hospitals operate under a system where they must make a choice between becoming more efficient or simply shift costs to offset underpayment from Medicare, Medicaid, and Blue Cross. The virtually routine response has been to shift costs.

In June, 1982, the HIAA held a press conference to announce a four-point proposal to reform the nation's hospital payment system, including: (1) establishment of state prospective payment systems to encourage cost containment and equity of payment; (2) temporary short-term state-by-state limits on permissible hospital revenue increases; (3) Federal legislation to allow insurers to join together to negotiate with hospitals to cut costs; and (4) appointment of a Presidential Commission on Health Care Payment Reform to make specific recommendations for reform.

Business Coalitions

The HIAA has become increasingly active over the past several years in the health care coalition movement. The Association was particularly instrumental in organizing coalitions in Maryland and Illinois and continues to work closely with these two groups both to evaluate cost containment activities and to maintain an open forum for discussion on health care system needs.

In addition, insurance representatives are active in coalitions across the country which are seeking to work with state legislatures on measures necessary to bring costs under control.

In 1982, the HIAA joined with five other major organizations in calling for the development of health care coalitions "as a means of solving some of the most pressing problems of the health care system." This national coalition includes: the American Medical Association, American Hospital Association, Blue Cross/ Blue Shield, Business Roundtable, the AFL-CIO, and HIAA.

Milwaukee Project

In 1979, the HIAA launched a three-year voluntary health care cost containment project in Milwaukee, Wisconsin. Involving a cooperative effort of employers and private health insurers the project had as its goal developing voluntary solutions to the health cost problem.

Much progress was achieved toward this goal, despite obstacles, with a number of "firsts" achieved. The project marked the first time that:

- Employers and insurers (despite antitrust constraints) worked together in a coordinated effort to control health care costs;
- Any group was able to develop a uniform data set with definitions available, as a resource for other interested groups;
- Any group has put together so practical a bibliography on successful cost containment techniques.

The project left in place the potential for a continuing health care cost containment program in Milwaukee, by mobilizing local initiatives, educating private groups on the value of cost containment efforts, and achieving high visibility within the community.

"Voluntary Effort" Initiative

In the late 1970s and early 1980s, the HIAA participated in the "Voluntary Effort" (VE) initiative of the hospital and medical professions. Association staff served on the VE steering committee whose responsibility was to coordinate a network of voluntary programs to limit the rise in hospital costs.

Despite its full support for these efforts, the HIAA was also an original supporter of President Carter's hospital cost containment bill in 1978.

PUBLIC INFORMATION AND HEALTH PROMOTION PROGRAMS

Health Insurance Communications Programs

In the fall of 1978 the HIAA launched a national advertising and public information campaign to alert the American public to the extremely serious threat of health cost inflation and the urgent need for effective solutions. This effort was known as the industry's "Health Insurance Communications Program" (HICP).

Over the year that followed, advertising messages appeared in key consumer magazines reaching 30-40 million thought leaders outlining workable approaches to cost containment from ambulatory and second opinion surgery and other alternatives to hospital care to health planning, prospective budget review, and health education.

In 1981, hospital cost shifting became the focus of the HICP in a concentrated effort, through national advertising, to bring this issue and the need to act upon it to the attention of opinion leaders at every level. This campaign had an exceptional public impact, with "cost shifting" becoming a widely recognized problem and subject for discussion by Congress, the media, and public groups.

Advertising was also conducted in several states in support of legislation for equity of payment by all payers.

Earlier this year the HICP addressed current deficiencies in the health care payment system, the barrier that cost shifting poses to cost containment, and the priority need for prospective payment applied equally to all payers.

This fall particular stress will be placed in national and select state advertising on the option created under the Social Security Amendments of 1983 allowing states to enact their own prospective payment systems. States will be urged to adopt such systems tailored to their own needs.

In each phase of the HICP, the HIAA has provided comprehensive kits of informational materials to member companies to assist them in carrying the prospective payment message to the many publics they reach.

As a result companies have conducted extensive public information efforts among their employees, policyholders, legislators, the media, and local business, labor, and professional leadership.

Health Promotion

In 1977 the HIAA joined with the American Council of Life Insurance in creating an Advisory Council on Education for Health. The Advisory Council, comprising eminent authorities in the health field, has as its mission providing guidance to the health and life insurance industries in making unique contributions to health promotion and disease prevention.

Its major initiative to date was the launching in 1977 of a three-year Lifecycle Preventive Health Services Study which has now been renewed for another three years. Being tested in three sites -- Appleton, Wisconsin; Danville, Pennsylvania; and Pensacola, Florida -- the study is currently being funded by 28 health and life insurance companies and two foundations.

The purpose of the study is to evaluate a new approach to improving health care for people of all ages by developing preventive health education procedures that can be applied by physicians in their daily practice.

The study uses a different package of preventive health services and counseling procedures for each of 10 age groups, starting with pregnant mothers and extending through old age. The cost of providing these services also is being studied, along with the impact on health care costs of educating patients on how their lifestyles affect their health.

In addition to the Advisory Council, the HIAA has had its own Health Education Committee, composed of insurance company representatives, for over 20 years. The Committee has sought to stimulate individual company interest and involvement in health promotion.

This year the HIAA, through the endeavors of its Health Education Committee, has put highest priority on "wellness" at the worksite. It has sponsored the production of a video presentation designed to encourage member companies to undertake or expand wellness programs for their employees and subsequently to promote similar activities among their group policyholders.

This new initiative was a direct follow-up to two earlier projects focusing on worksite wellness.

In 1980, the HIAA sponsored a national conference for insurance industry executives on health promotion in the workplace.

In 1981, the Association commissioned Dr. Charles Berry, former chief medical director of the U.S. Space Program and a member of the insurance industry's Advisory Council on Education for Health, to prepare a study on the cost effectiveness of worksite programs. The subsequently published study "Good Health for Employees and Reduced Health Care Costs for Industry" is today widely recognized as a major contribution to the literature on health promotion.

This year, too, the HIAA and ACLI through their Center for Corporate Public Involvement is sponsoring an industrywide program to promote smoking cessation and prevention programs among employees and their families. Soon to be released is a manual prepared by the former director of the Office on Smoking and Health, HHS, which is designed to provide guidelines to insurance companies to assist them to plan, organize, and implement non-smoking programs.

These Association sponsored activities are very much in keeping with earlier HIAA policy positions. The Program for Health care in the 1970s which became the Burleson-McIntyre Bill called for greater emphasis on preventive care as a means of containing health costs. And the 1977 HIAA "Program to Contain the Costs and Assure the Quality of Health Care" stated:

> "Preventive care and health education programs should be expanded by insurers, employers, schools and other groups to motivate people to adopt more healthful life styles, seek early diagnosis and treatment, and follow doctors' instructions."

Association activities in this area have also been consistent with the rising insurance company interest in health promotion, particularly in the past decade. A February, 1983 survey by the HIAA/ACLI Center for Corporate Public Involvement revealed that a large majority of the 150 responding insurance companies sponsor various types of wellness activities for their employees. These include smoking cessation, cardio-pulmonary resuscitation, exercise/fitness, hypertension, screening and control, weight control, nutrition, stress management, heart attack and cancer risk reduction, and employee assistance programs.

A number of companies also provide health education materials to policyholders and/or sponsor school or community programs. The most popular of these are blood donor campaigns, "run for your life" events, high blood pressure screenings and drug/alcohol abuse programs.

The HIAA/ACLI survey further indicated that nearly 90% of the responding companies offer premium discounts to non-smokers on their life insurance contracts and about 15% offer non-smoker discounts on health insurance contracts.

How these activities have expanded was revealed in the 57 large company survey conducted by the HIAA in 1981. In that year, for example, 51% of the responding companies said they distributed health education literature to policyholders or the community. Ten years earlier only 14% of the companies did so.

In keeping with its concern about the detrimental effects of smoking, the HIAA has actively supported legislation requiring stronger warning labels on cigarette packages. This support has been communicated to all members of the Senate Labor and Human Resources Committee, which recently approved such legislation, and to the House Energy and Commerce Committee.

* * *

Despite antitrust constraints, the HIAA and its member companies have vigorously pursued many and varied means to curtail the rising costs of health care. Health care cost containment will continue to be of the highest priority to the nation's private health insurers.

QUESTION No. 2

ARE THERE ANY BARRIERS FOR THE INSURANCE MARKET TO REDUCE COSTS IN HEALTH CARE? SPECIFICALLY, ARE THERE BARRIERS TO INSURANCE COMPANIES NEGOTIATING PRICES WITH PROVIDERS?

ANSWER:

Yes. Unlike the noninsured plans with which insurers compete, insurers are subject to stringent state regulation. Our product design creativity is also stifled by a range of provider protection laws. Unlike our chief competitors in many instances, we pay state premium taxes and federal income taxes on the earnings on our reserves. Further, the highly competitive nature of our business and the antitrust laws preclude us from negotiating prices with providers and collaborating effectively for other cost containment purposes.

First, what we would like to see is a "level playing field" for all third party payors, including Medicare and Medicaid.

When Medicare pays less, private payors pay more--in effect constituting a hidden tax on non-government patients which amounted to almost $6 billion in 1982, will be $7.9 billion in 1983, and is expected to reach $11 to $12 billion by 1985.

We find that many individuals and employers are increasingly frustrated when they realize that a large and growing portion of their health care expenses is paying not for their own care--over which they have at least some control--but for care given to public patients. We estimate that 16 percent of the hospital expenses incurred by our policyholders is being paid for care rendered to Medicare and Medicaid patients.

This cost shift would severely impede the ability of private payors to compete with government programs under Medicare voucher system such as that proposed by the Administration.

We want Medicare to pay on the same basis as other payors. The provision in the recently-enacted Social Security Amendments providing for Medicare recognition of qualified state hospital payment programs is a major step in the right direction.

Another possibility would be to require Medicare-approved hospitals to allocate equally among all private patients that portion of their budgets not reimbursed by Medicare or Medicaid.

Second, as with the Medicare cost shift, state regulation does not apply evenly to various classes of payors. Employers that self-insure employee welfare benefit plans are exempted from state regulation by the preemption clause in Section 514(c) of ERISA. Such noninsured plans are not subject to the myriad legislative and regulatory requirements imposed upon insured plans. These requirements, which vary considerably from state to state, typically include a wide range of mandated benefits, free choice of provider provisions, and continuation of coverage and conversion options which are often quite costly. Employers may avoid these obligations as well as the necessity of maintaining reserves and paying premium taxes simply by not insuring their plans.

In order to nurture competition in the health care field, we should assure that all competitors are subject to the same rules.

Insurance laws and regulations serve a beneficial purpose in protecting the insured public. However, ERISA now precludes the states from regulating the affairs of noninsured health plans, but at the same time the federal government has failed to regulate these health plans.

The very fact that these plans are unregulated makes them increasingly attractive funding alternatives for employers. Indeed, as much as 50 percent of the new health-related business written by major insurers is no longer conventional health insurance. This is an obstacle to competition that we are not able to overcome without Congressional support.

It is also a very real impediment to innovative plan design by insurers.

We recommend that Congress require that state taxation and regulation apply equally to all funding mechanisms. We are not proposing a substitution of federal for state regulation. However, our business does support, for example, Section 3605(a)(ii)(I) of S. 1541 (the Retirement Income Incentives and

Administrative Simplification Act, introduced by Senator Nickles) which would amend ERISA to preempt state mandated benefit laws for insured as well as for non-insured employee benefit plans. This simple change would be a first step along the way to more equitable competition and more rational benefit design.

Third, we would like to set up programs in every state, as we have done in Connecticut, to guarantee the availability of health insurance to all individuals. However, again, ERISA is a major barrier to our seeking state laws setting up these programs. We feel strongly that all competitors in the employee health benefit market should share proportionately in any program losses. However, ERISA preempts state laws to the extent those laws require self-insured plans to participate in these state programs. Thus, self-insured plans are effectively shielded from the economic burden of the guaranteed availability programs, a burden which falls on an ever-decreasing base caused by existing legal barriers to equitable competition. The program could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools and requiring all employee health benefit plan funding mechanisms to participate in such a pool as a condition of income tax deductibility or by otherwise requiring self-insured employers to participate in such programs.

Fourth, in a similar vein, there are any number of state laws enacted to protect the interests of different classes of providers. These laws often operate to prevent the establishment of preferred provider plans by insurers and stand in the way of negotiations between insurers and providers. They essentially preclude any insurer from restricting in any way any beneficiary's "freedom to choose" any health provider the insured wishes. An interesting experiment is beginning on this subject in California; and we should know before too long whether competition among providers will be enhanced by California's new law allowing an insurer to negotiate with providers. Note, the California law still does not allow more than one insurer to jointly negotiate.

Last, we would like to share data and engage in joint cost containment activities, such as negotiating prices with health providers, the development of physician profiles and patterns of care, and other such activities.

Insert X

The insurers ability to individually negotiate with hospitals to accept less than their charges as full payment has been very limited. Hospitals have agreed to such requests to voluntarily reduce their revenues only where an employer or insurer has sufficient volume to force acceptance. Some Blue Cross plans and the Rochester-employer coalition so dominate their local areas as to be successful in obtaining such discounts.

For the vast majority of the country, however, neither the insurance company nor the employer has sufficient local volume to negotiate charges and thereby prevent cost shifting. To drive home the point, the Prudential, which is the single largest private health insurer in the country, has only 4% of the private health insurance market, and that is spread over 50 states. The insurers are too dispersed to negotiate individually and are prohibited by antitrust laws from negotiating jointly. Therefore:

1. Insurers should be authorized jointly to collect, analyze and use information on the quality, cost, or utilization of health care services, including the development of reasonable, or preferred utilization practices as guides for insurance reimbursements to providers. In other words, commercial insurers should be able to join together to assemble data.

2. Insurers should also be empowered collectively to negotiate prices with health care providers as well as utilization standards. It should further be possible for insurers jointly to contract with review organizations to provide peer review and concurrent hospital review for private patients and to provide data to such organizations.

QUESTION No. 3

IN YOUR TESTIMONY, YOU ADVOCATE "ALL-PAYOR" PROGRAMS WITHIN STATES. HOW WOULD YOU JUSTIFY THIS REGULATORY STRONG HOLD ON STATES SUCH AS UTAH WHO HAVE SUCCESSFULLY DEVELOPED A MARKETPLACE ORIENTED TOWARD COMPETITIVE PRICING AND AWARE CONSUMERS? DOESN'T YOUR BROAD APPROACH LIMIT OTHER APPROACHES IN REDUCING HEALTH CARE COSTS?

ANSWER:

No, our approach does not limit other approaches; is not proposed as the sole remedy for high health costs; is designed to provide maximum flexibility to the States, such as Utah, with the least possible intrusion from the Federal government; and should enhance competition among third-party payers by providing a more equitable market place for the competitors.

In the Social Security Amendments of 1983 the Congress provided that Medicare would recognize, for payment purposes, state hospital cost containment programs which meet the Federal standards set by Congress. One of the standards is that the program cover essentially all payers. The standards do not require any particular type of program, such as DRG or rate review. They are in essence performance standards, and in fact specifically forbid the Secretary of HHS from requiring a DRG-type program as a condition for Medicare participation.

The HIAA simply proposes that the Congress give the states four years to enact a program meeting these standards which are already in the law. After four years a Federal hospital prospective pricing system would be extended to all payers, not just Medicare, in any state which had not enacted its own qualified program. This would give every state time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve.

The HIAA believes the Federal law is needed to provide the incentive for the states to act, but that, given four years, every state will have time to act in its own fashion, that the states will act, and that there will, in effect, never be one form Federal all-payer system.

The HIAA strongly opposed the Administration's attempt to force its DRG system on the states as a condition of Medicare recognition and applaud the Congress for giving the states flexibility in this area. The four states currently engaging Medicare waivers, Maryland, New Jersey, Massachusetts, and New York all have vastly different programs, yet all are qualified. DRG's may work well in New Jersey, but we would oppose and have opposed, their being required of any other state, such as Utah, as long as that state devises its own system which passes the Congressional performance test.

We do not believe this precludes other steps to contain health care costs and have specifically suggested or endorsed a number of other legislative measures, ranging from health planning to stronger cigarette labeling to authorizing insurers to jointly negotiate with providers. We have also proposed a Presidential Commission with representatives of all parties at interest to come to grips with the difficult issues involved in a cooperative way for the good of all. There is no one easy answer.

The CHAIRMAN. Thank you, Mr. Roberts.

Mr. Seidman, we are happy to turn to you.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL-CIO, FALLS CHURCH, VA.

Mr. SEIDMAN. Thank you, Mr. Chairman.

My name is Bert Seidman, I am director of the Department of Social Security of the AFL-CIO.

I have a statement and I would appreciate it if it would be put into the record.

The CHAIRMAN. Without objection, it will go completely in the record.

Mr. SEIDMAN. I will try to summarize the highlights.

The AFL-CIO is pleased to have this opportunity to present its views on health care cost containment. In recent years rising health costs have imposed an extremely heavy financial burden on the Federal Government and—I wish to stress this—on all health consumers.

We heard statements this morning which seemed to imply that patients are not concerned about the cost of health care because they regard either medicare or the programs that as union members, for example, have been negotiated as being costfree. Well, they are not costfree. Patients are required to pay a great deal of money out of pocket. That money, out-of-pocket money paid for health care, is increasing. It is money that insurance does not cover. Frequently, senior citizens and now many, many families of jobless workers are going without essential medical treatment.

Organized labor has long been concerned about uncontrolled increases in health care costs. We vigorously supported comprehensive health cost-containment when it was last under consideration by the Congress and have given strong support to efforts to enact statewide cost containment systems. Our affiliates and local unions have made major efforts to control rising costs both through collective bargaining and through participation in local health care coalitions.

Conservative theorists—and we heard some of them this morning—blame patients for the current health care crisis. They believe that skyrocketing increases in health care inflation can be reduced dramatically by making individuals more cost conscious. We hope that this committee will not be persuaded by this unfounded rhetoric. Too often so-called cost consciousness if a clever euphemism for less coverage and higher out-of-pocket payments for beneficiaries while the real decisionmakers in the health care system—hospitals and physicians—continue to increase costs and raise fees without restraint.

We see three factors determining the level of health care inflation—price, utilization, and intensity. From 1967 to 1978, inflation accounted for 50 percent of the annual increase in medicare costs. The next largest category, 36 percent, was intensity of services such as improvements in technology.

Contrary to the commonly held view, nonlabor costs account for 70 percent of the figure. Increases in the medicare population account for 12 percent, and the smallest category, less than 2 percent, was utilization reflecting increased demand.

In this connection, Mr. Chairman, I would like to address an issue which is repeatedly misrepresented, and that is the impact health care workers have on health care costs. Most health care workers have been and continue to be underpaid, earning less than workers in other industries. Their real income has been declining, and over a long period of time payroll costs as a percent of total expenses in hospitals have been declining.

Mr. Chairman, the AFL-CIO believes a cost-containment system ought to apply to all payers and include all providers. Rather than proposing thoughtful categories to contain costs, we think that the Reagan administration has given the Congress a blueprint for slashing current services and protections. These measures are punitive and have hurt health consumers while allowing doctor fees and hospital charges to soar to new record levels. This morning we heard the administration representatives propose further slashes in health care programs which would still further hurt consumers.

The AFL-CIO supports S. 814, introduced by Senator Kennedy. We favor the concept of prospective budgeting applied to all payers, public and private, and including physician services as well as hospital care. S. 814 would encourage States to develop their own programs within Federal guidelines. Under that bill, special allowances would be given to innercity and public hospitals, which are the providers of last resort for the poor, the elderly, and those with nowhere else to go.

The present problems associated with high inflation, reduced access and uneven quality of care, would not now exist had Congress enacted universal comprehensive national health insurance as the AFL-CIO has long recommended. We will continue to work toward that goal, but organized labor believes we cannot wait to bring health care inflation under control. Therefore, we urge the Congress to immediately enact a comprehensive, across-the-board, cost containment program for all payers along the lines of S. 814.

Thank you, Mr. Chairman.

[The prepared statement of Bert Seidman follows:]

83-50

TESTIMONY OF BERT SEIDMAN
DIRECTOR, DEPARTMENT OF SOCIAL SECURITY
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE ON
HEALTH CARE COST CONTAINMENT

May 19, 1983

The AFL-CIO is pleased to have this opportunity to present its views on health care cost containment.

In recent years rising health costs have imposed an extremely heavy financial burden on the federal government and all health consumers. Federal expenditures for health care, insurance premiums and medical fees have skyrocketed, and patients are required to pay a great deal more money out-of-pocket for services that insurance doesn't cover. Frequently, senior citizens and families of jobless workers go without essential medical treatment and, in some institutions, the quality of care dispensed is directly related to the patient's ability to pay.

Organized labor has long been concerned about uncontrolled increases in health care costs. We vigorously supported comprehensive hospital cost containment when it was last under consideration by the Congress and have given strong support to efforts to enact statewide cost containment systems. Our affiliates and local unions have made major efforts to control rising costs through collective bargaining and participation in local health care coalitions.

Conservative theorists blame patients for the current health care crisis. They believe that skyrocketing increases in health care inflation can be reduced dramatically by making individuals more "cost-conscious." We hope the Committee will not be persuaded by this unfounded rhetoric and will look at the facts. For "cost-consciousness" is a clever euphemism for less coverage and higher out-of-pocket payments for beneficiaries, while the real decision makers in the health care system, namely hospitals and physicians, continue to increase costs and raise fees without restraint.

There are three factors which determine the level of health care inflation in a given year: price, utilization and intensity. According to the Health Care Financing Administration, during the period 1967 - 1978 inflation accounted for 50 percent of the annual increase in Medicare costs. The next largest category (36 percent) was intensity of services, such as improvements in technology. Contrary to the commonly held view, non-labor costs account for 70 percent of the figure. Increases in the Medicare population account for 12 percent. The smallest category (1.9 percent) was utilization, which reflected increased demand. The problems which must be solved, therefore, are how to reduce the price of medical care and change incentives within the current reimbursement system which encourage unnecessary testing and other procedures. Despite present efforts to reduce Medicare coverage, unless we can bring inflation, excessive testing and unnecessary surgery under control, there will be no end to rising expenditures.

In this connection, Mr. Chairman, I would like to address an issue which is repeatedly misrepresented. That is, the impact health care workers have on health care costs. Most health care workers have been and continue to be, underpaid. According to the Bureau of Labor Statistics, non-supervisory health care workers earn almost 15 percent less than workers in other industries. Their real income has been declining and in 1980 was 6 percent lower than in 1972. In effect, hospital workers have been unfortunate scapegoats for the real villains in the health care system. Everyone in this room has heard workers being blamed for health care inflation. Yet from 1965 to 1980 payroll costs (supervisory and non-supervisory), as a percent of total expenses in community hospitals, declined from 62 to 49 percent. Contributions for fringe benefits also declined.

The point is there are no easy answers to the problem of rising health care costs. Mr. Chairman, the AFL-CIO urges this Committee to be skeptical of those who blame our current health care crisis on those who work in and are served by the health care system. For until the providers and suppliers of health services have real incentives for cost effective behavior, as a nation we will continue to pay a great deal more for less.

For some years the AFL-CIO has thought the health care system poorly managed and that incentives which would make hospitals more cost-conscious ought to be added to public and private health insurance programs. However, we believe a cost containment system ought to apply to all payors and included all providers, including physician services. In addition, and perhaps most important, no cost containment system should worsen the already unequal balance between the haves and the have-nots in our system.

The Reagan Administration's approach to our current health care crisis has been to attack public health and entitlement programs and paint them as villains undermining our nation's economy. Rather than proposing thoughtful strategies to contain costs, it has given Congress a blueprint from which to slash current services and protections. The drastic cuts that were passed by both Houses of Congress have encouraged hospitals to turn away Medicare and uninsured patients. Employers now have strong incentives to lay off older workers, rather than pay more for health insurance, and national immunization programs and health services for mothers and children have been drastically cut back. All of these measures are punitive and have hurt health consumers, while allowing doctor fees and hospital charges to soar to new record levels.

One of the Reagan Administration's responses to the nation's health care crisis is its so-called competition proposal, which would save money for employers and the federal government at the expense of working families and the elderly who would be encouraged to play Russian roulette with their health.

Although organized labor supported the Administration's proposal to introduce the concept of prospective budgeting into the Medicare system and to discontinue the practice of paying hospitals whatever they spend, we believe that the only way to bring total health care costs under control, is to enact an across-the-board cost containment system for all private and public payors.

There is strong evidence to suggest that a prospective reimbursement system for Medicare alone will give hospitals strong incentives to turn away all, or certain types of, Medicare patients and could also encourage facilities to shift unreimbursed costs onto employees, employers and already overburdened state and local governments. A far better course would be enactment of a comprehensive all-payors cost containment system along the lines of S. 814 introduced by Senator Edward M. Kennedy.

The AFL-CIO supports S. 814. We favor the concept of prospective budgeting applied to all payors, public and private, and including physicians services as well as hospital care. S. 814 would encourage states to develop their own programs within federal guidelines. Under the bill special allowances would be given to inner-city and public hospitals which are the providers of last resort for the poor, the elderly and those with nowhere else to go.

The present problems associated with high inflation, reduced access and uneven quality of care would not exist had Congress enacted universal comprehensive national health insurance, as the AFL-CIO has long recommended. We will continue to work towards that goal. But organized labor believes we cannot wait to bring health care inflation under control. We urge Congress to immediately enact a comprehensive across-the-board cost containment program for all payors along the lines of S. 814. We also urge Congress to reject the Reagan Administration's proposed budget cuts in the area of health care, which would penalize beneficiaries and discourage them from seeking needed health care treatment while allowing the providers and suppliers of services to increase costs at uncontrollable rates.

The CHAIRMAN. Thank you, Mr. Seidman.

I have been very interested in both your statements. I am going to submit questions to you. I have a number of questions for both of you. If you could answer them as quickly as possible, we would appreciate that.

I think these hearings have been quite interesting because we have been talking about some of the problems here, not the solutions. Next week we are going to go into some of the solutions.

You have given us what the AFL–CIO believes are some solutions. You have given us what the insurance industry believes are some solutions. There have been some other suggestions here today as well.

I think these hearings have at least opened up a lot of questions in my mind and a lot of questions in the minds of other members of this committee, and hopefully the general public.

I do not know of any issue that is as important as this for the purpose of resolution for the benefit of all taxpayers and all members of our society. I just hope that we will be able to come up with some solutions that will work and that all of you will feel happy about.

I appreciate the efforts that you have put forth. I appreciate the statements that you have given. Of course, we will recess these hearings until next week when we will listen to some other aspects.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

[The material referred to follows:]

AMERICAN MEDICAL ASSOCIATION
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JAMES H. SAMMONS, M.D.
Executive Vice President

April 1983

TO: Executive Directors
State Medical Associations
Metropolitan/County Medical Societies
National Medical Specialty Societies

SUBJECT: AMA Cost Effectiveness Evaluation Network

As you know, the AMA in cooperation with the American Hospital Association (AHA) and the Federation of American Hospitals (FAH), is currently implementing a nationwide network of 75 hospitals to conduct and evaluate a variety of cost effectiveness projects which focus on clinical and administrative issues in the hospital setting. The selection of the hospitals which are being invited to participate in the Network has been made on the basis of random sampling criteria so that the Network includes a representative number of the acute care hospitals in the United States. Attached is a brief description of the sampling methodology that was applied to the AHA Masterfile in order to select the hospitals for the Network, and a list of the hospitals which have accepted the invitation to participate.

The initial project selected for implementation in the Network is a protocol for holding Economic Grand Rounds. The objective of this project is to enhance physician awareness of the costs of the services they order through the use of the grand rounds as a teaching forum. A written protocol is used to develop a presentation whereby participating physicians are able to explore and discuss both the clinical and fiscal issues associated with a particular case history. The Economic Grand Rounds protocol has been successfully pretested in five hospitals. Physicians who have participated in these discussions have found that they are better able to examine their own practice patterns and decide when and how they can be most cost effective without compromising the quality of medical care. Overall, the medical staffs in the pretest hospitals have found this process useful and beneficial to themselves as well as to their patients.

The implementation and operation of the Network is a cooperative effort within organized medicine. In today's economic and legislative climate, private sector initiatives in the area of cost effectiveness are essential. We believe that the Network program is one such initiative and additionally, that participation in such a program may help physicians and hospitals to deal with today's changing regulatory and market forces.

A description of the Network program and its goals is attached. If you have any questions, suggestions for hospitals to participate in the Network, or ideas for cost effectiveness projects to be evaluated in the Network in the future, please call or write Louis J. Goodman, Ph.D., Director of the AMA's Department of Health Care Financing and Organization (312-751-6470).

Sincerely,

James H. Sammons, M.D.

JHS:cw
Attachment

AMERICAN MEDICAL ASSOCIATION

COST EFFECTIVENESS EVALUATION NETWORK

ECONOMIC GRAND ROUNDS

A Program of
the American Medical Association
in cooperation with
the American Hospital Association
and
the Federation of American Hospitals

Second Edition

April 1983

AMA COST EFFECTIVENESS EVALUATION NETWORK

The Cost Effectiveness Evaluation Network is one of the American Medical Association's ongoing programs in the area of cost effectiveness. Based on the recommendations of the National Commission on the Cost of Medical Care, these activities are designed to demonstrate the Association's commitment to private sector efforts to minimize the growth of health care costs in ways that are consistent with high quality medical care.

The Cost Effectiveness Evaluation Network is an initiative, cosponsored by the American Medical Association, the American Hospital Association, and the Federation of American Hospitals, which is aimed at involving hospital medical staff and administrators in collaborative cost effectiveness activities focused on practice patterns and clinical/administrative issues in the hospital setting. The Network will consist of approximately 75 hospitals located throughout the country that will implement and evaluate a limited number of cost effectiveness projects. The purpose of the Network is twofold:

- To develop and test practical cost effectiveness activities in the hospital setting; and
- To demonstrate — in a political atmosphere that stresses voluntarism in the private sector -- that the Associations and the participating hospitals have taken the initiative on the hospital cost issue.

In short, the Network will provide a vehicle through which a coalition of organized medicine and hospitals will be able to demonstrate that the care being provided in this, the most costly treatment setting, is being delivered efficiently and effectively.

As the Network's first activity, a model for holding Economic Grand Rounds (EGR) is being tested. The overall objective of this project is to enhance physician awareness of the costs of the services they order through the use of the grand rounds as a teaching forum. Presentations will be developed whereby participating physicians explore and discuss both the clinical and fiscal issues associated with a particular case history. The Economic Grand Rounds initiative has essentially four operational goals:

- To encourage practicing physicians to reflect on their practice patterns in the context of cost effectiveness issues;
- To reinforce existing clinical behavior which is directed toward the cost effective delivery of high quality medical care;

Division of Health Program Development, American Medical Association, January 1983

- To change physician behavior where appropriate to reflect more cost effective delivery of high quality care; and

- To stimulate additional subsequent activities geared to foster the cost effective delivery of medical care.

Rationale for Economic Grand Rounds Project

Since physicians play such a key role in determining how and when medical services will be used, many of the studies involving utilization and/or cost effectiveness in medical care focus on phsycians, their practice patterns, and efforts to change some of those practice patterns. The evidence from much of this research suggests that appropriate physician educational efforts can enhance the cost effective delivery of medical care. Many of the studies show, however, that while an educational program may have an effect in reducing specific utilization patterns or redirecting resources in a more cost conscious fashion, the effect is only temporary unless it is incorporated into a continuing program. The sponsorship of this EGR project gives evidence of organized medicine's commitment to private initiatives in pursuing the goal of delivering more cost effective, high quality medical care. This project provides physicians and administrators with an opportunity and a mechanism by which an educational cost containment effort can be launched in their hospital and then incorporated into a continuing program.

Historical Background

The Network is sponsored, in cooperation with the American Hospital Association and the Federation of American Hospitals, by the Subcommittee on Cost Effectiveness of the AMA's Council on Medical Service. The project has been developed by the Subcommittee with the support of the AMA Department of Health Care Financing and Organization. Economic Grand Rounds protocols have been field tested at five sites in various areas of the country with a great deal of success and enthusiasm. An implementation package has been developed from the original EGR protocol based, in large part, on the experience gained from the pilot hospital site visits.

The overall operational goal of the Network project is to develop each successful cost effectiveness activity into a project implementation package that is adaptable and can be made available to any hospital interested in replicating a particular project. Each of these kits will contain step-by-step implementation instructions and extensive discussion of both the benefits and logistics of implementing that project. The 75 hospital nationwide Network is a testing ground for projects such as the Economic Grand Rounds prior to their being made generally available. Evaluation, therefore, will be a key facet of the Network's activities.

Elements of an Economic Grand Rounds Program

The implementation of a meaningful program of Economic Grand Rounds in a hospital on a long-term basis requires three essential elements in order to be successful:

1. The formal discussion and consideration of cost effective elements of medical care through presentation of appropriately chosen clinical cases and their corresponding financial records in a classic medical or surgical grand rounds setting;
2. Reinforcement of these considerations through follow-up presentations and/or discussions at appropriately timed intervals; and
3. Evaluation of the impact of the program immediately following the initial presentation and at appropriately timed intervals thereafter.

The implementation package for the Economic Grand Rounds project proceeds step-wise through many of the logistical issues and operational details of implementing such a program in a hospital, beginning with the initial decision to participate in such a project. Discussed in some detail are such issues as the selection of cases appropriate to an Economic Grand Rounds discussion, the collection and categorization of the appropriate financial data, preparation for the actual presentation and discussion, and options for potential follow-up activities to the Economic Grand Rounds.

Future Activities

The Economic Grand Rounds project is the first of many projects which will be evaluated by Network hospitals. It is envisioned that one or two projects per year may be selected for implementation by the participating hospitals. At no time would a hospital which is a member of the Network be required to implement any specific project. Potential future projects currently under consideration for future activity in the Network might include such topics as the development of models for improved efficiency in the use of diagnostic resources.

AMA COST EFFECTIVENESS EVALUATION NETWORK
HOSPITAL SELECTION CRITERIA

The AMA Cost Effectiveness Evaluation Network consists of more than 80 hospitals invited to participate from among the short-term acute care general hospitals in the 48 contiguous states. In order to insure fair geographic representation from each area of the country, the more than 7,000 non-federal, short-term general hospitals on the AHA Hospital Masterfile were randomly sorted by geographic region. The hospitals were also randomly sorted by such criteria as bed size, urban/rural location, ownership, and teaching/non-teaching status. Using these criteria, a total sample of 300 hospitals was drawn, since replacement hospitals would be necessary to substitute for hospitals who were invited but chose not to participate. Attached is a list of hospitals which have agreed to participate in the Network program.

List of Participating Network Hospitals

ALABAMA

Mr. Joseph L. Harris, Vice President
for Business Affairs
Baptist Medical Centers - Princeton
701 Princeton Avenue, S.W.
Birmingham, Alabama 35211

Mr. Wendell Briggs, Administrator
J. W. Herod, M. D., President
of the Medical Staff
Coffee General Hospital
400 North Edwards Street
Enterprise, Alabama 36330

ARIZONA

Mr. Daniel W. Capps, President and
Chief Executive Officer
Stuart M. Gould, M.D., Chief of Staff
Camelback Hospitals
5055 North 34th Street
Phoenix, Arizona 85018

Mrs. Carolyn A. Elson, Executive
Vice President and Chief Administrator
Richard Fox, M.D., Chief of the
Medical Staff
Phoenix Baptist Hospital and Medical
Center
6025 North 20th Avenue
Phoenix, Arizona 85015

CALIFORNIA

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(NOTE: In the interest of economy, additional material submitted for the record by the American Medical Association entitled "AMA Cost Effectiveness Plan: 1983 and Beyond," "The Minnesota and Philadelphia Stories," and the National Commission on the Cost of Medical Care Summary Report, December 1977, were retained in the files of the Committee where they may be researched upon request, or additional copies of these reports may be obtained by contacting the Order Department OP-149, American Medical Association, P.O. Box 821, Monroe, Wis. 53566.)

ADA American Dental Association

STATEMENT OF

THE AMERICAN DENTAL ASSOCIATION

ON

HEALTH CARE COSTS

TO

THE COMMITTEE ON LABOR AND HUMAN RESOURCES

U. S. SENATE

May 19, 1983

Washington Office: 1101 17th Street NW Washington DC 20036 (202) 833-3036

The American Dental Association is pleased to have this opportunity to outline the factors which have enabled the dental profession to significantly improve the level and extent of dental services provided to the public while exhibiting significant restraints in increases in the costs of those services. It is most impressive to note that since 1967, which is the base year of the Consumer Price Index until now, dental care costs as measured by the CPI have increased by only 155%. This compares to an increase for all goods and services under the CPI of 165% and the considerably higher increase in physician fees (190%) and hospital charges (360%).

This impressive record is based on several factors including: the profession's emphasis on prevention, advances brought about by dental research, increased use by dentists of auxiliary personnel, an increased supply of dentists and the unique structure of dental benefit programs.

Prevention of oral disease is a very basic foundation of the dental profession. Fluoridation of community water supplies is perhaps the most effective preventive measure known. Dentists also incorporate basic preventive techniques as part of their practices. This commitment to prevention helps to eliminate diseases before they occur thereby eliminating the need for expenditures to treat those diseases.

Developments in dental research have assisted the profession in preventing disease. They also have resulted in equipment which permits the dentist to be more efficient and in materials which assure a better oral health for individuals. The expanding use of auxiliary personnel trained to perform specific functions in a high quality manner also has significantly increased the efficiency, and therefore reduced the costs, of providing dental care. A related consideration is the fact that approximatley 85% of dentists are general practitioners. The level of specialization has not increased significantly over the years. At the same time, the supply of specialists is adequate to meet the demand for complex or extremely difficult dental treatment procedures.

One of the most dramatic changes affecting the dental profession over the last 15 years is one which under most circumstances would be expected to have greatly increased the costs of dental care. In 1967 approximately 6 million Americans received prepaid dental benefits. Currently almost 90 million Americans receive dental benefits. This extraordinary growth in coverage has resulted in a very significant increase in the number of individuals who are seen by a dentist each year. However, the record of the dental profession, as noted in the opening paragraph of this statement, has been one of consistent and significant cost control.

Increased productivity, emphasis on prevention and advances in research all have contributed to the moderation shown in dental prices. However, the profession also believes that the structure of dental benefit plans has played a significant role in controlling costs at a time when such enormous increases in potential demand have been experienced.

Dental benefit plans actually help to control dental costs by rewarding patients who take care of their teeth in order to avoid oral diseases requiring costly restorative care. Major dental benefit plans generally cover 100% of the cost for diagnostic and preventive treatment - routine oral exams, teeth cleaning, flouride treatment and other types of care intended to help patients stop dental diseases before they start.

As treatment requirements become more costly and complicated, patients must pay a larger share of the cost. Major plans generally provide higher levels of benefits for basic restorative services (tooth fillings, for example) than for major restorative treatments such as crowns and bridges.

This method of weighting benefits assures that all plan subscribers maintain a financial interest in their oral health - and share the cost of restoring it when disease occurs. If patients fail to properly care for their teeth, they will have to pay more out of their own pockets.

As mentioned earlier there has been over a 1200% growth in the number of individuals covered by dental plans in the last 15 years. And during this period of unprecedented growth in dental plans, per capita dental premium costs actually declined, according to the Health Insurance Association of America. Co-payment requirements featured in dental benefit plans have helped control dental service costs by encouraging individuals to care for their teeth. Patients are more likely to preserve their good health when they know that failing to do so will cost them more money.

It also should be stressed that the vast majority of Americans who are covered under dental plans receive these benefits through employer sponsored programs. It is extremely ironic then that current proposals to impose a tax on employees for certain employer health benefits contributions not only will not affect the most expensive elements of the health care system, hospital and medical care, they will provide incentives for employees to forego dental benefit plans. The irony is that these dental plans should be the model for financing health care on a cost effective bases. We are strongly opposed to such proposals which would not be effective in controlling costs but would penalize those plans which have been most cost effective.

A booklet amplifying the impact of such a health tax on dental benefits is attached.

The dental profession is proud of its record in providing the best oral health care. It is equally proud that its emphasis on prevention, both in the dental office and in the structure of dental benefit plans, has permitted the profession to provide this care to increasing numbers of people while effectively controlling the costs.

Thank you for this opportunity to express our views.

The **Chairman**. Thank you so much.

[Whereupon, at 12:39 p.m., the committee recessed, to reconvene at the call of the Chair.]

HEALTH CARE COST: DEFINING THE ISSUES, 1983

WEDNESDAY, MAY 25, 1983

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The committee met, pursuant to recess, at 8:49 a.m., in room SD-430, Senator Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Hatch, Stafford, Quayle, Nickles, Grassley, Hawkins, Kennedy, Pell, Eagleton, Riegle, and Matsunaga.

OPENING STATEMENT OF SENATOR HATCH

The CHAIRMAN. The committee will be in order.

It is my pleasure to chair this second day of hearings on health care costs. We began this discussion on May 19 by describing the multiple causes associated with high inflation and health care.

Today we turn our discussion toward possible solutions to reverse the trend.

First, let me briefly describe what we learned last Thursday.

For two decades, health care spending in the United States has risen dramatically. Current spending, both public and private, continues to soar while the economy as a whole is showing very little growth.

There are numerous and complex factors that affect health care spending. The most important components are prices, population changes, utilization of services, and intensity of services provided to patients.

While general inflation contributes to a little over half of the inflation experienced in health care costs, the remaining increase is due to changes in the composition of goods and services consumed by patients.

We learned from Mrs. Heckler, Secretary of the Department of Health and Human Services, who has control of over 23 percent of all health care spending, that we should not be concerned with simply the number of dollars being spent on health care but instead look at the evidence that the Nation's health care system is not as efficient as it should be.

She further stated that the "challenge before us is to preserve the quality of our health care system while making the system more efficient and more productive."

Furthermore, we learned from the consumers and providers of health care that the status quo is not a viable alternative in reducing health care costs and that other solutions will not be simple. Multiple initiatives need to be undertaken, and there are serious risks if we as a nation do not begin to address health care inflation. Health care in the United States may not remain the quality system we now command unless we do.

Now that we understand the problems we face within the health care market, what can we as a nation do to reduce health care costs while retaining quality health care?

Consumers in the United States expect quality health care—and, indeed, the United States provides the best medical care in the world. We as a nation have the best physicians, nurses, technologists, researchers, and hospital workers. But, in 1982, approximately $350 billion was spent on health care. That is, we are spending money for longer lifespans, better technology, experienced and well-trained health professionals, which all equates to a higher cost for care.

But our current form of reimbursement for health care services shields consumers from the true cost of care. A poll conducted in Utah learned that while Utahans are concerned with health care costs, 75 percent would seek hospital care regardless of the cost; yet less than half felt that hospital costs were fair.

So what can we as a nation do?

Since the status quo is not a viable alternative, I propose that a regulatory approach to containing costs will not be, and has not been proven, viable. Estimations state that just eight Federal regulations add $22 daily to each hospital bill. Approximately 38 million patients were admitted to the hospital during 1982. That means that $836 million in 1982 went to administer Federal regulations in a hospital setting.

Existing Federal regulations include health planning laws, Hill-Burton regulations, health manpower laws, et cetera. Now, I am not saying that some of these laws are not important, but I can say that they have not reduced the current inflation existent in the health care marketplace.

Therefore, I am one who agrees that our present system for health care has interfered with the operation of natural market forces. So I support market-oriented approaches and voluntary private sector efforts to alter the health care marketplace.

Congress has begun to address the problems of federally financed health care by imposing a change in the way hospitals are reimbursed for patients' hospital care. Instead of cost reimbursement, now hospitals will be paid on a diagnosis-related group charge basis. This new system rewards efficient delivery of care, while hoping to insure that hospitals are adequately paid for their services.

In addition, Congress is looking at other alternatives to reduce health care costs. I, for one, am an advocate of increased competition among the suppliers of health services and wider consumer choice and greater price sensitivity in the selection of health benefit protection.

Other areas I support in reducing health care costs are increased health promotion and disease prevention activities by businesses, communities, and localities. I hope they will continue their efforts in stimulating healthy lifestyles among our citizens.

Also, I am a supporter of alternative delivery systems which provise diversity for our systems and increased competition.

Also, I do not support existing health planning laws. These laws, while intended to reduce health care costs, have proven ineffective in reducing costs and effective in increasing the strangulation of hospitals with burdensome regulatory tape.

Finally, I am a supporter of President Reagan's health care reform package to reduce health care costs. As Mrs. Heckler stated, the administration's proposals call on all participants in the marketplace for health services—physicians, hospitals, nurses, insurers, consumers, employers, and government—to work together and share the responsibility for controlling costs.

The program endorsed by President Reagan makes the Federal Government a prudent purchaser of care and acts as a catalyst to encourage other payers to do the same. While this legislative package in its entirety may not be fully supported by all organizations, I see it as the alternative to cost containment proposals of nationalized medicine which others in Congress would offer as the only way to reduce costs. President Reagan's proposal removes barriers to a freer marketplace in the health care cost arena.

We will now receive a statement by Senator Kennedy.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. I am pleased to join you in this second day of hearings on health care costs. Our first day's witnesses came from different backgrounds and perspectives. But they agreed on one thing. Health care inflation is out of control and seriously threatens the well-being of our citizens.

A number or our witnesses offered constructive suggestions for how to curb the health cost problem. We learned that State cost containment programs have held per admission costs to a rate of increase 3 percent below the national average. We heard testimony concerning HMO's ability to hold down the rate of increase on insurance premiums, while conventional insurance premiums continue to skyrocket.

I regret that the administration has failed to take advantage of these promising initiatives. Instead, the administration pushes ahead with its harsh approach—charge consumers more, create new barriers to cost-effective primary and preventive care. Rather than focus on the physician who influences 70 percent of all health care decisions the administration would prefer to blame the patient. Instead of requiring physicians to accept medicare reimbursement as payment in full, they propose to charge the elderly $8 billion more for hospital care over the next 5 years.

They say they want to make consumers more cost conscious. The working people of America are amply aware of the cost of health care—they pay for 29 percent of it directly out of their own pocket.

The challenge is not to shift costs to the consumers—but to implement meaningful measures that will lead to greater efficiency throughout the health care system. By reforming our reimbursement system, placing new emphasis on primary and preventive care, and encouraging alternative systems like HMO's, we can achieve significant cost savings—without slamming the door to health care for the poor, the elderly, and the working family.

The **Chairman**. Today we will hear differing viewpoints on how to reduce health care inflation. We are grateful to have testifying President Reagan's economic adviser, Dr. Martin Feldstein. In addition, we will hear from two other noted health care economists. Also testifying will be witnesses from two States who have taken opposite approaches to containing health care costs, and finally we will learn from a panel of consumers and providers their proposed methods to solve our existing health care financial crisis.

It is indeed, at this time, my pleasure to welcome the esteemed Dr. Martin Feldstein to our hearings to discuss solutions on the costs of health care. Dr. Feldstein's presence indeed adds an extra dimension to our hearings because he is one of the most respected economists in our Nation today.

Presently, Dr. Feldstein is the Chairman of the Council of Economic Advisers at the White House. He advises the President on all economic issues and, in fact, today he will have to leave early to make final preparations with President Reagan for this week's economic summit meeting in Williamsburg, Va.

Prior to his position with the President, Dr. Feldstein was noted for his work at Harvard University in tackling the economic issues surrounding the health care marketplace. In view of the double-digit inflation currently experienced in the health care market, I look forward, Dr. Feldstein, to your proposed solutions to this issue.

We really do appreciate your taking time to be with us today, and we were glad we were able to accommodate you at what is normally an early hour in the Senate.

So I would be happy to have your statement at this point.

STATEMENT OF MARTIN FELDSTEIN, CHAIRMAN, COUNCIL OF ECONOMIC ADVISERS

Mr. **Feldstein**. Thank you very much, Senator. I am very pleased to be here this morning.

I have a statement which you have, but I understand that in order to save time we will dispense with the statement and go directly to questions.

I might just say one thing, though, which summarizes what I have said in the statement. That is that I agree with you that we have a serious problem now, that health care costs, and hospital costs in particular, have been rising at unacceptable rates year after year for more than a decade, and that the only way to get a handle on them is to change the incentives in the marketplace that have been pushing costs up in this way.

The primary reason is that we have a health insurance system which, in effect, removes all concern with costs on the part of either physicians or patients. With insurance paying roughly 90 percent of all hospital bills, it is hard for either patients or physicians to show anything like adequate concern for the costs and resources that are being expended.

The proposals that the administration has put forward in the medicare area and in the private insurance area are designed to change the character of insurance and to make patients and physicians and providers in general more conscious of the costs of those resources.

[The prepared statement of Mr. Feldstein follows:]

PREPARED STATEMENT OF MARTIN FELDSTEIN, CHAIRMAN, COUNCIL OF ECONOMIC ADVISERS

Mechanisms to Solve Health Care Cost Inflation

Martin Feldstein*

I am pleased to appear before this committee to comment on the important subject of limiting the rise of health care costs. Health care costs continue to rise at an unacceptably high rate despite the general decline in the rate of inflation. In 1982, the medical care component of the consumer price index rose 11.0 percent while the average rise in consumer prices was only 3.9 percent. The increase in hospital costs has been particularly rapid. Last year, the average cost of a patient day in short term hospitals was increasing at an annual rate of more than 15 percent. Between 1966 and 1981, hospital cost per patient day rose at an average rate of 13.6 percent while consumer prices rose only about half as fast, an average rate of 7.1 percent. Now the average cost of a day of hospital care is more than $350.

The unusually rapid rise of the cost of hospital care reflects the changing character of the hospital's product. Hospital care today is more sophisticated, more expensive, and hopefully more effective than it was a decade ago. Unfortunately, though, the cost of care has risen at a pace that imposes unacceptable financial burdens. Moreover, the rise in hospital cost does not reflect what patients and their doctors really believe to be appropriate levels of expenditure but has been severely distorted by our insurance system.

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*Chairman, Council of Economic Advisers. Presented to the Senate Committee on Labor and Human Resources, Washington, D. C., May 25, 1983.

In 1983, insurance, both private and public, pays about 90 percent of the cost of hospital care. As a result, patients at the time of care pay only about 10¢ of every dollar of hospital costs. It is not surprising that patients and their doctors therefore choose extravagantly expensive care and that hospitals compete for patients by providing more and more sophisticated and expensive services.

It has not always been this way. In 1960, health insurance paid only 65 percent of the cost of hospital care and the average cost of a day in the hospital was only $32. Over the years, the extent of insurance rose rapidly and propelled the rise in demand for expensive care that has caused the explosion of hospital costs.

The purchase of health insurance is a natural and useful response to the uncertain possibility of large medical expenses. But the major reason for the growth of very comprehensive "first dollar" hospital insurance has been the special tax advantage that health insurance receives. Employer payments for health insurance are currently completely excluded from the taxable income of both the employer and the employee. Unlike pension contributions and employer payments for life insurance, there is currently no limit on the amount of such tax-free health insurance premiums purchased by employers. An individual with a 30 percent marginal tax rate can save $600 in taxes if his employer pays $2000 for health insurance premiums and can save $900 if his employer pays $3000 for health insurance. Moreover, someone with a 50 percent marginal tax rate can save $1,500 a year in taxes if his employer pays $3,000 for health insurance.

Although health insurance has an important part to play in protecting families from unexpected large health care costs, the current excessive use of insurance is a reflection of a distorting tax subsidy. The Administration therefore proposes to bring the tax treatment of health insurance into line with the tax treatment of pensions and life insurance by putting a limit on the amount of tax free payment that employers can make in this form. In particular, the Administration has proposed a $175 a month limit on employer payments for health insurance premiums. Limiting the tax subsidy in this way would cause employees and employers to choose health insurance more wisely. With less extensive insurance, patients and their doctors would be more careful about the use of hospital services.

Experts generally believe that health insurance should focus on providing protection against very large expenses that might otherwise have devastating financial effects on patients. Insurance payments for relatively small health care bills are much less appropriate because they provide little protection against uncertain risks but do distort the medical care decisions of patients and physicians. Limiting the amount of the health insurance premium that can be provided tax free is likely to cause individuals and employers to shift their coverage in an appropriate way.

The same principle of concentrating insurance on large expenses guides the Administration's proposal to reform Medicare. Under current law, a Medicare patient may exhaust his or her hospital insurance at the end of 60 days in the hospital and be forced to meet additional expenses out of pocket. The Administration proposes to eliminate this risk of catastrophic costs by paying for unlimited hospital coverage after 60 days' hospitalization each year. To finance this extra protection and to help maintain the solvency of the troubled Medicare trust fund, the Administration proposes a copayment of $28 a day for the second through 15th day of a hospital stay, and $18 per day for the 16th through 60th day.

This shift in the Medicare coverage would thus serve three useful purposes. First, it would improve the insurance protection of Medicare patients against the risk of large hospital bills. Second, it would improve the trust fund resources available for paying future Medicare benefits. And, third, it would decrease the overall cost of hospital and medical care.

The relation between inappropriate health insurance and the rising cost of hospital care is a subject that I have been studying for more than a decade. On the basis of that research, I can enthusiastically recommend the health insurance reforms recently proposed by the Administration.

1/ Several articles that previously appeared in academic journals and brought together with new comments in Martin Feldstein's Hospital Costs and Health Insurance. (Harvard University Press: Cambridge, Massachusetts and London, England, 1981.)

The **Chairman**. I appreciate those comments.

I might mention that, without objection, your statement was placed in the record in its entirety, as though delivered.

Let me ask you just a few questions.

What are the consequences if current health care cost trends continue unabated?

Mr. **Feldstein**. What we are doing is using a larger and larger share of national income to finance more and more sophisticated care, taking money away from things that people would frankly rather be spending it on, but because of the way in which we are financing our health care now, through employer payments or through taxes, patients don't have that choice.

The **Chairman**. So what are the implications of health care cost strategies which address only Federal programs?

Mr. **Feldstein**. Federal programs, of course, are a major part of total health care spending at this time, through medicare and medicaid, but they are only a part, and I think it is important that whatever is done has to be done in parallel for private spending on health care and for the public programs.

The **Chairman**. If health care regulations played a major role in the explosion of health care costs, what effect do they have on current costs?

Mr. **Feldstein**. They have had, as far as I can tell, very little effect in dampening the explosion of health care costs.

The **Chairman**. If anything, they have aggravated it, haven't they?

Mr. **Feldstein**. I think they have indeed, in many cases, aggravated costs, prevented more efficient providers from getting into the markets and providing lower cost alternatives.

The regulatory route, I think we have seen, in industry after industry, just does not work. And here is an opportunity, I think, to strengthen the market rather than to impose more regulations.

The **Chairman**. I was interested in the Washington Post article this morning, the headline of which was, "Consumer Price Index Jumps 0.6 percent in April." They concluded that a big jump in gasoline prices helped push the Consumer Price Index up a seasonally adjusted 0.6 percent in April, ending a remarkable string of 8 months in which the CPI rose an average of less than 0.1 percent a month.

Now, they say that the 4 percent increase in gasoline prices was only part of a broader rise in prices last month. Then they go on to say that food, shelter, and medical care costs all rose 0.5 percent, and the category of other good and services increased 0.7 percent.

What is the impact of that, and how do you analyze that?

Mr. **Feldstein**. Medical care costs have been rising much more than other costs month after month. During that remarkable string—and it goes back to September—in which we had no overall increase in the Consumer Price Index, we nevertheless saw the medical care component going up at a very substantial pace. Indeed, last year, 1982, the Consumer Price Index rose less than 4 percent, but the medical care component of the Consumer Price Index rose 11 percent, so that we have just not been able to bring health care costs and the inflation of health care costs back into line, even at a time when we have been so successful in bringing inflation in general down. I think it reflects the fact that health care cost increases are so different from other kinds of cost increases.

It is not merely that the cost of providing the same product is going up year after year but that the product itself is changing. Under the pressure of insurance, hospitals are providing more and more tests, more sophisticated services, and that is pushing up the cost at a much faster rate than prices in general.

The CHAIRMAN. Would you please describe what, in your opinion, really is the most important factor contributing to the inflation in medicare costs, and why has public spending for health care increased tenfold during this period, which is twice the rate of private spending?

Mr. FELDSTEIN. Well, I would say that, in general, the most important factor is insurance. The payment by public and private insurance programs, including medicare and medicaid, has increased dramatically, and has come to provide a much larger share of total spending on health care. That has removed any price consciousness, any sensitivity to costs, on the part of physicians and patients.

When medicare and medicaid were introduced in the mid-1960's, that represented a significant jump in the share of costs being paid by third parties, by public or private insurance, and that accelerated the rate of increase of costs, especially hospital costs, and led to the fact that you referred to, the fact that Government outlays were going up even more rapidly than outlays by the private sector.

The CHAIRMAN. I see.

In your testimony, you support bringing the tax treatment of health insurance into line with the tax treatment of pensions and life insurance by putting a limit on the amount of tax-free payment that employers can make in this form.

Now, while I generally agree with this philosophy, I am still concerned with the equity of the tax cap proposal, especially what effect it will have on low-income workers and small businesses.

What part of our population will be most affected by changes proposed in the administration's health incentives reform program?

Mr. FELDSTEIN. Well, I am very glad you asked that because I think it is a source of potential confusion.

It is quite clear that putting a cap on the exclusion of health insurance benefits by employers and requiring the additional payments by employers to be included in personal income will matter much more for high-income individuals than it will for low-income individuals.

Those individuals who pay no taxes now are likely to be completely unaffected by the change. Individuals in the high-income brackets tend to have the best, most comprehensive, most expensive health insurance. They are the ones most likely to find that the tax cap really matters, that it does require an addition of taxable income to their current taxable income.

Let me give you some figures. We have estimated that if the tax cap were put in place for 1983, less than 2 percent of households with incomes under $10,000 would be affected. Less than 2 percent!

If you look at incomes of households under $15,000, less than 5 percent would be affected. By contrast, if you look at households with incomes in the $50,000 to $100,000 class, about 36 percent would be affected.

So it basically is a change which more or less exempts low-income households, either because they are not subject to personal income tax or because, more generally, they do not have the kind of rich, very expensive health insurance plans that we are proposing to cap.

And then, if you look at the amount of additional tax that would be paid by those who are affected, looking at that $50,000 to $100,000 income class, those who are affected would pay an average of $323 more in taxes.

Looking down at the under $10,000 class, it would only be about a third as much, $138.

Now, if you combine those two facts—much more tax in the high-income brackets than the low-income brackets for those who are affected and a much greater chance that you will be affected if you are in the high-income class—you can see that for the typical taxpayer under $10,000, the amount is very small. On average, among all taxpayers under $10,000, we are talking about less than $3 on average per taxpayer, while, when we get up to the $50,000 to $100,000 class, we are talking about more than $100 per taxpayer.

So this is really going after a loophole in the tax law which primarily affects upper income individuals.

The CHAIRMAN. I see.

With the shift of hospital payment to a per-case basis rather than a cost-reimbursement basis, what should the hospitals do to pay for their uncompensated care costs? What would they do?

Mr. FELDSTEIN. I think the important thing is that they will have a very strong incentive to cut back on their costs in excess of the reimbursable amount. They are not going to be able to find a way of paying for it except in small amounts, and they are going to have to adjust their costs correspondingly.

The CHAIRMAN. I see.

Do you think there needs to be a bipartisan health care cost commission, something on the order of the Social Security Commission, addressing health care cost increases, and to also address the projected deficits in the health insurance trust fund or in medicare itself?

Mr. FELDSTEIN. I like to think that Congress can do these jobs itself. [Laughter.]

The CHAIRMAN. However, you know better, don't you? [Laughter.]

Mr. FELDSTEIN. Well, if by default——

The CHAIRMAN. I am not so sure that commissions do the job, but——

Mr. FELDSTEIN. I think that it would be much better to see the Congress, which has been studying these issues for some time, of which many of you are quite knowledgeable and have access to all kinds of experts and additional advice, deal with the problem directly.

The CHAIRMAN. To what extent is the generally increasing number of doctors in total supply of doctors generating competitive forces in the marketplace? Should the Federal Government continue to supply money to train these professionals?

Mr. **Feldstein**. I think, in terms of the basic problem we are talking about today, it has a relatively small effect. There is a lot of controversy among those who have studied the question about whether providing more physicians increases or decreases total costs.

There are those who think that having, particularly, nonspecialist physicians, having general practitioners, encourages more nonhospital care, more treatment of the same patients outside hospitals, and that reduces overall cost of care.

Obviously, providing more hospital-based physicians tends to increase the demand for hospital services. So it can cut either way.

The **Chairman**. As a principal adviser to the President, what single item would you encourage him to urge enactment of in order to get some reduction in the inflation experienced in health care costs while retaining quality services, if you had your choice?

Mr. **Feldstein**. Well, I think this general principle of shifting the character of insurance to emphasize catastrophic rather than the complete payment of small bills is the key principle, and that is why that has been embodied in both the medicare proposals that we have offered and also in the tax cap for private insurance.

The **Chairman**. There are many in Congress who feel that our efforts should be directed solely toward the providers of care. Do you feel that the exclusive problem rests with the providers, and would encouragement of a voluntary effort, as was done between 1978 and 1982, be of benefit in reducing health care costs?

Mr. **Feldstein**. I think as long as the pressure is there from the patient who says, "I am fully insured; I want the most sophisticated care that can be provided," purely voluntary programs on the part of the hospitals and physicians cannot do the job. We have to change the incentives if we want a decentralized system to work.

The **Chairman**. I have some other questions, but I know that you have to leave by 9:20 at the latest.

Why don't we turn to Senator Quayle at this time?

We will keep the record open to allow members of the committee to submit written questions to you.

Mr. **Feldstein**. Fine.

The **Chairman**. Senator Quayle?

Senator **Quayle**. Thank you, Mr. Chairman.

I want to thank you for continuing to hold hearings and show an interest in a very important problem.

I would like to welcome Dr. Feldstein.

I would just like to comment on the commission concept. We have gotten through the Social Security Commission and we have gotten through the Scowcroft Commission. I see the President is now going to have another commission to see about the actual deployment of the MX. There has been talk about a commission on arms control. I heard even last night at a dinner I was attending that there is serious talk about appointing a commission to deal with the deficit.

I agree with Dr. Feldstein that we have really gone far enough on this commission idea.

I know we do have a bipartisan commission on the medicare problem. Dr. Bowen, former Governor of Indiana, is the head of it. He tells me privately it will not give us welcome news on what we are going to have to do to put medicare on a sound basis.

I have not read your entire statement. Do you address the medicare insolvency issue at all?

Mr. FELDSTEIN. Not directly, no.

Senator QUAYLE. Let me just ask this question. If we would impose perhaps the most vigorous cost competition or health competition or cost control or however else you want to refer to it, is that going to be sufficient to deal with the medicare problem that we have in the health insurance trust fund of social security? Can we do it? The argument has been made that you can do it just through cost control, cost containment, and that we really don't have to look at the benefit side or the revenue side.

Mr. FELDSTEIN. My sense is no, you cannot do it just by slowing the growth of health care costs.

Senator QUAYLE. That we cannot?

Mr. FELDSTEIN. We cannot.

Senator QUAYLE. There is no way that we can do it solely by health care costs.

Mr. FELDSTEIN. That is why, in the administration's proposals, as you know, we have changes in the part A and part B premiums as part of that.

Senator QUAYLE. What will your proposals do as far as slowing down the growth of the increase in health care costs? Are they going to have an actual impact on health care costs?

Mr. FELDSTEIN. They will have an impact. They will tilt it in the right direction. They will not have a dramatic effect. But I think we are now in a situation where our health insurance laws are giving a blank check to employers and employees to buy the most expensive kind of insurance with very substantial subsidies from the taxpayers, and we have to start turning that around.

Senator QUAYLE. I am sure that you are probably aware of some of the private sector initiatives to try to grapple with the problem of health care costs, particularly some of the larger companies that have quite high premiums to pay on their insurance bills.

There seems to be coalitions developing around the country. I know that in my home State of Indiana there is a rather active coalition in Fort Wayne of business people that are coming together to try to deal with this problem in the absence of the health systems agency and health planning.

I wonder what kind of encouragement we can give those types of groups. Is there a Federal role that could be played with these groups, or should we just let nature take its course?

From my viewpoint, at least, I believe that there is a big constituency out there in the name of small business men and women and small businesses in this country that are really at some time going to bring a lot of pressure on the Congress and politicians to do something about the premiums that they are paying on health insurance. I have an example of a small business in my hometown that employs less than 50 people, and their insurance premium has doubled in the last 3 or 4 years. This is going to be of much concern and growing interest.

I just wonder, as this voluntary initiative seems to be taking hold, how could we sort of foster that and help it? Is there anything that we can do?

Mr. **Feldstein**. I don't really know. I would say, though, that they have an uphill battle in that we have an environment which so encourages the use of extensive health insurance.

I don't know if you were here when I began this morning. I pointed out, as I do in the statement, that now 90-plus percent of hospital bills are paid by health insurance, public and private. It is very hard, in an environment like that, to imagine any kind of effort will really turn around the dramatic pressure for continually increasing sophistication, expensiveness, rising costs of hospital care. The health insurance companies are increasing their premiums because their costs are going up and not because they are making profits. Most of the large companies, nonprofit and for-profit and Blue Cross, are at best breaking even on their underwriting business in the health area. It is a very unfortunate situation in which the dramatic rise in costs is continually being propelled by a health insurance environment which makes patients and doctors and administrators insensitive to rising costs. That is what we really have to turn around.

Senator **Quayle**. And let me just pick up on that. In regard to the rising costs, there has been an argument advanced that health planning helps keep down rising costs. I would presume that you would concur that health planning should be more of a State function rather than a Federal function, particularly the certificate-of-need requirement for any kind of expansion of hospitals.

If that is so—that is true; you would prefer that to be a State responsibility and a State function. Am I correct?

Mr. **Feldstein**. Yes.

Senator **Quayle**. If that is so, do you think that there is any role, on a decentralized basis, for the Federal Government to be involved in the area of health planning? Health planning was a mixed record. I personally believe, with the experience in Indiana, it was proven to be tremendously bureaucratic and inefficient.

On the other hand, there are some cases that they can point out as far as unnecessary expansion, unnecessary capital expenditures of hospitals, they in fact have had a role, and a very successful role. So it is sort of a mixed blessing.

I wonder what you think the role of health planning is or could possibly be.

Mr. **Feldstein**. I don't want to put myself forward as an expert on that, so I think I would mislead if I tried to give a judgment on balance on that subject.

The counterargument, of course, is that in many cases health planning has kept inefficient institutions alive; it has prevented alternative forms of care from getting started; and that it has protected the status quo rather than providing new means of competition for bringing costs down.

I keep coming back to my one basic theme that all of these kinds of changes, regulatory changes, voluntary programs, cannot buck the tide of demand pressure. And to the extent that they are successful in bottling up the demand that is naturally there when you have insurance paying 90 percent of the bills, they are going to lead, in general, to misallocations of resources, and that we really should be trying to get at the fundamental problem of getting people to restructure the insurance.

We have created the kind of insurance system we have had for the private sector largely because of the tax rules. I think we have developed and designed public insurance in medicare and medicaid modeled on what private individuals have come to buy because of the tax rules, and if we don't start to deal with this fundamental problem of the design of health insurance, there is not much that we are going to do to stop the day from coming when we have to throw up our hands and say this has to be run completely by the Government because the market has been destroyed here.

Senator **QUAYLE**. Well, I hope we never get there.

The Chairman has very politely slipped a piece of paper under my nose to say to cease so that Senator Nickles can have an opportunity to ask questions. [Laughter.]

I thank you for coming, Dr. Feldstein. I certainly thank the Chairman for continuing his efforts in this area.

I hope that perhaps we can go beyond a couple of proposals that the administration has proposed, because this issue is not going to go away, and it is something that we are going to have to grapple with on a political and intellectual basis as well.

The **CHAIRMAN**. There are very few issues that are really going to be as cost-important to any administration in the future as some effective way of resolving the health care cost issue.

Let's turn to Senator Nickles, and you will be the last to question this morning. Dr. Feldstein really should leave in a couple of minutes. But why don't you go ahead?

Senator **NICKLES**. Thank you, Mr. Chairman.

Dr. Feldstein, a couple of comments, I guess, in kind of a follow-up to what Senator Hatch had and also Senator Quayle. I think the enormous problem that we are looking at in health care is two-fold—one for private and also for Government. When we see the deficits that are forecast for medicare, I think there is no question that we have an awesome responsibility to start laying some groundwork now to insure that those deficits do not occur and that we try to take some steps in the right direction.

I will compliment the administration for some of the proposals that you have made. I think the idea of cost sharing does have some relevance, and I think that again is Government trying to look at the private sector, because the private sector has been doing just that.

One question I do have on your proposal is on the limitation on the monthly deductible on health and accident premiums. I have some concern that I am afraid maybe we might be penalizing some firms that perhaps do not have exceptionally generous health and accident benefits as you and I would know it, but maybe they happen to be rather small and have very high experience ratings; they have had some very expensive cancer treatments, heart treatments, et cetera. So, as a result, over this low pool of people, their experience rating has been very high, and therefore their premiums are very high.

If we go in and tell those individuals, well, we are sorry that you happen to be in this group; you have been in good health; you happen to be 22 years old with 2 children and never even filed a claim; but yet we are going to tax part of this benefit because you happen to be in a group that happens to have high experience ratings. I am not sure that that appears to me to be very equitable.

Mr. **Feldstein**. I think that we are talking about such high levels of monthly premiums—$175 a month—that that is not likely to be an important problem. We are talking about very comprehensive insurance at more than $2,000 a year. Certainly somebody could still have, no matter how bad the experience rating of that firm, a very substantial insurance package available at $175 a year and pay no tax under this.

Senator **Nickles**. I think what you would do is see a recrafting. I know in the firm that I have been associated with, we have restructured a little bit and gone where the company ended up insuring the first couple of thousand dollars maybe on a coinsurance basis or an 80-20 or 90-10 or something like that, and then actually only purchased major medical insurance, which is what you are kind of coming back and saying, that we will provide the major med portion.

But really, this company and other companies, I think, found themselves to where they could not afford the health and accident insurance, to some extent, and so they were self-insuring for the first amount, whatever they could bite off.

How do you handle something like that? In other words, their insurance may be comparable, if they went out to a marketer, Travelers or someone, and Travelers might say, well, we couldn't provide that unless you give us $250 a month.

Mr. **Feldstein**. You would have to talk to the Treasury to get a definitive answer, but my understanding would be that we would have to combine those two; that is, to the extent the employers self-insure, that would be treated as if it were a health insurance premium purchase.

Senator **Nickles**. I hate to see us do that. I mean, a lot of employers have taken those steps because health and accident insurance——

Mr. **Feldstein**. There would be, in any sense, no discrimination against that, and to the extent that it is cheaper to do it that way than to purchase insurance, it will be encouraged by these provisions which put a cap on the total.

Senator **Nickles**. Again, I am not sure that you will be encouraging it. I know that is your intention, and I applaud your desire, but what I am saying is, you may have some cases where companies are trying to do this, and somebody could come in and say, Oh, you are self-insuring for the first $2,000 and you are doing it on an 80-20 or 90-10 basis, but that has an economic value. How do you determine that? Well, are you going to divide it by the number of claims that you had that year and by the number of participants?

If you did something like that, you could well discourage that very type of activity. I am just concerned that maybe you are going to be penalizing firms that maybe have high experience that I don't think you are really trying to penalize. Maybe they didn't have overly generous plans; they just happened to have some high experience ratings, and you could be hitting them on a little bit of a double whammy.

I wanted to make that point to you and also raise a concern. I noticed in the House committee where they passed health and accident insurance for the unemployed, I personally have some reservations about that, primarily from the cost standpoint. When we see this program, medicare, expanding, when we see the cost to the Government expanding, how can we afford an additional—I have seen some efforts that some have tried to restrain that, but it seems to me that that could be a very expensive program in a very short period of time.

Do you concur with that? Do you know if the administration is going to oppose that?

Mr. FELDSTEIN. Well, I don't have an estimate of the cost on that, and I think I would rather not try to give you an estimate of the cost of that at this time.

Senator NICKLES. But it is a very serious problem. It is one that has surfaced, but I am not sure that it has been examined thoroughly as to its potential scope of persons that could be covered, would be covered, the possible expense not only this year but what it might be in 5 years or 10 years or 20 years, and it is one that I would hope would be looked at before we find ourselves into a new entitlement program and one that this Government can hardly afford.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Nickles.

Senator Kennedy has a couple of questions. He will try to be brief.

Senator KENNEDY. Just a few questions.

Mr. FELDSTEIN. Senator, it is good to see you.

Senator KENNEDY. It is nice to see you.

Mr. FELDSTEIN. I am sorry I am going to have to—I would be delighted to talk with you privately, but I really have to go. I should have left before because I am supposed to be meeting with the President in 15 minutes.

Senator KENNEDY. All right. Well, I will just take just a very few minutes.

First of all, I want to welcome you here to the committee.

Second, I differ dramatically with your prescription for the solution of the health care cost problem. I will just touch on a couple of areas and get some quick reactions.

Your suggestion in your statement that it is not surprising that patients and their doctors choose extravagantly expensive care, I think basically misstates the problem. It is the doctors that make the decisions, not the patients.

Having spent 7 months in the hospital myself with a broken back, having been in hospitals with children that have needed surgery, having studied this issue, I find it difficult to find how you can possibly justify that statement. It is the doctors.

Mr. FELDSTEIN. The question is why do doctors choose the care that they do choose now differently than they did before, differently depending upon the insurance the patients have, and so on.

So I think it reflects decisions taken by the doctors who are aware of the financial position, including insurance, of the patients.

Senator **Kennedy**. Yes, but the fact is that the doctors are the ones that are making those decisions, and the recommendations that are being made by the administration, that you are going to have increasing cost sharing just misses the mark, because it is the doctors that are the ones that put the people in the hospitals; it is the doctors that are the ones that are making the recommendations in terms of various tests; and it is not the patients.

If you have other evidence on that, I wish you would supply it.

The second point concerns the administration's medicare hospital proposal.Your statement is one of the most disingenuous comments before this committee on health matters. On page 4 you point out, "First, it would improve insurance protection of medicare patients against the risk of large hospital bills." In fact, it is going to cost the elderly people $8 billion more.

Mr. **Feldstein**. It is going to provide insurance protection against large bills which are not presently there.

Senator **Kennedy**. It will benefit 150,000 elderly people, and 7.5 million elderly people will pay more. Now, that ought to be included in any honest testimony before this committee. For you to recommend and say it would improve the insurance protection of medicare patients against the risk of large hospital bills is basically a distortion, a misrepresentation of what the administration proposes. You get 150,000 people that would actually benefit; 7.5 million that will pay more.

Second, it would improve the trust fund resources——

The **Chairman**. Did you have a comment on that?

Senator **Kennedy**. I am giving him just the words——

Mr. **Feldstein**. I really have to go. I am very sorry, Senator. I really must go. I would be delighted to talk about this more later, but I really do have to go. I am sorry.

The **Chairman**. I did commit that you would be able to leave by 9:20.

Senator **Kennedy**. Well, could he comment just on that one?

Mr. **Feldstein**. Yes, let me comment on just that one.

I have been buying health insurance for a number of years. I pay more than I get back in benefits. I nevertheless think it is a good thing to go on buying it. I think what I do is, I reduce the risk of very large expenditures by paying a little more.

What you are saying is that we are going to restructure health insurance to reduce the risk of very large, crippling health insurance costs of the aged, and in doing so, we are going to finance it by asking everybody else to pay a little bit more, and I see nothing objectionable about that.

But I really do have to go now.

The **Chairman**. Well, thank you, Dr. Feldstein. We are happy to have you with us, and I apologize for keeping you 15 minutes beyond what I said I would do.

Mr. **Feldstein**. I am very sorry to have to go.

The **Chairman**. All right.

As I understand it, we are going to recess now for a committee markup, and we are going to continue with these hearings as soon as the markup is over.

If we could ask staff to get our Senators here, I would appreciate it.

[Whereupon, at 9:30 a.m., the committee proceeded to other business, after which, at 9:50 a.m., the hearing was resumed.]

The **Chairman.** Let's reconvene our hearing on health costs.

Our second panel consists of two distinguished economists noted for their work on health care economics. We hope to gain from them varied solutions to curtailing the costs in our health care marketplace.

Our first speaker will be Dr. Frank Sloan. Dr. Sloan is the director of the Health Policy Center at the Vanderbilt Institute in Nashville, Tenn.

The second speaker will be Dr. Uwe Reinhardt, who is professor of economics at the Woodrow Wilson School at Princeton University in New Jersey.

So, Dr. Sloan and Dr. Reinhardt will proceed.

[Pause.]

The **Chairman.** Senator Kennedy commented that I really run a tight committee here. [Laughter.]

They tell me these witnesses are here. [Laughter.]

Senator **Kennedy.** You have probably kidnapped one of mine. [Laughter.]

The **Chairman.** Senator Kennedy, we would never do that to you.

Dr. Sloan, let's begin with you. We are glad to have you here. We welcome both of you to our committee, and we are sorry for the interruption, but we were going to try to have a markup. It is an important markup. If you can move one of the mikes to you and the other one to you, we would appreciate it.

So we will begin with Dr. Frank A. Sloan, who of course is the director of the Health Policy Center at the Vanderbilt Institute in Nashville, Tenn.

Dr. Sloan?

STATEMENT OF FRANK A. SLOAN, PROFESSOR OF ECONOMICS, DIRECTOR OF HEALTH POLICY CENTER AT VANDERBILT INSTITUTE FOR PUBLIC POLICIES STUDIES

Mr. **Sloan.** Thank you, Mr. Chairman and members of the committee, for inviting me to present my views on options for controlling the rise of health care costs.

I know that you looked at some of the factors that have contributed to the rise in health care last week. Certainly a number of factors can be identified, and since those were talked about last week, I won't go into them.

But certainly a major one is increased insurance coverage of the type that gives neither patients nor providers an incentive to conserve.

Each of the costs of health care cost inflation have some policy solutions associated with them. I will only look at a few of these here.

Health care cost inflation is old news by now. A number of cost containment initiatives were implemented during the 1970's. We do have evidence on the efficacy of these, and I just want to go very quickly through this.

Virtually all States implemented certificate of need. However, the majority of statistical evaluations of this program indicate that the approach holds no promise for health care cost containment. In fact, the chief beneficiaries are existing providers who, at least to some extent, are protected from potential competitors.

I would see certificate of need as being eliminated. I just don't see how it contributes to the solution at all.

PSRO's have also failed in cost containment. For utilization review to be effective, physician reviewers must benefit financially from saying no, and doctors have this incentive when they are at risk for expenses in excess of premium income, when they are members of an IPA or a prepaid group practice, but they don't under the fee for service. Unfortunately, PSRO's offer no meaningful financial incentive, and I don't see this type of program contributing, either, to cost containment.

Findings from several recent studies indicate that mandatory rate-setting programs implemented by a few States have as a group achieved cost savings. The average annual reduction was something like 2 to 3 percent a year, and this would have to be seen as a consequential reduction.

However, several noteworthy particulars lurk behind this general conclusion of an overall cost savings. None of the programs generated savings during the first 2 years. There is some doubt that rate-setting would be as successful in States with different political climates than those in which it was tried.

Now, looking to the 1980's, the prospective payment plan for hospitals recently enacted by Congress for Medicare gives hospitals an unmistakable incentive to be efficient. There is room, however, for additional cost savings, particularly on the admissions side. Admissions could be curbed with patient cost sharing—I know there is some cost sharing in the medicare program already—or with capitation; that is, a fixed payment rate per patient.

The public sector potentially has a great deal of leverage in dealing with health care, more than has been used to date. Rather than try to contain costs by dealing with individual providers, when administratively feasible, government should establish contractual relationships with cost-effective groups of providers with the capitation rate being the price rather than the fee-for-service being the unit of payment. These contracts may be established through competitive bidding and, in some cases, by direct negotiation.

I do find the experiments with competitive bidding in a number of western States very interesting and worth watching. These States are to be congratulated for taking the lead in this area.

Government should not give in to pressure from private insurors and others for rate setting covering all payment sources. This is unless we completely abandon the current system. How can there be meaningful competition when, by regulation, everyone pays the same price?

As an interim but second-best measure, medicare should consider ways to combine hospital and physician payment under the DRG system. A mandatory program of this type realistically faces serious implementation problems, but it may be the way that we have to go if in fact we cannot develop ways to encourage capitation, which is a more comprehensive way of involving the physician in health care cost control.

Now, looking to the private sector, the tax subsidy of private health insurance premiums should be markedly reduced. By lowering the price of insurance, the current subsidy encourages employees to demand first-dollar coverage. Furthermore, the subsidy is highly objectionable on equity grounds because it primarily benefits the upper middle and upper classes.

Data we have collected at Vanderbilt show this quite conclusively. There are other studies that show this as well. So, even on equity grounds, if you cannot accept the efficiency-enhancing features of a tax cap, the equity grounds would support looking at the tax cap.

The substantial revenue loss attributable to the current subsidy is also regrettable. A frequent criticism of the tax cap is that there is no hard evidence that limiting this subsidy will cause the public to reject first-dollar coverage and shop for insurance that yields best value for the premium dollar. No one can guarantee this will happen. There is not the evidence out there to say that we are sure that this will happen. However, even if it does not, the fact that people want to continue their complete coverage at least gives us a better sign than we have currently that this is the type of protection that the public will demand when they have to pay for it themselves. And, of course, a tax cap will raise badly needed additional tax revenue.

There is a need to maintain antitrust enforcement in the health care field. As competition among alternative delivery systems becomes more widespread, there will be attempts to deny innovators, innovative plans, access to hospitals. There will be more sophisticated group boycott activity, and there will be disputes involving payment to nonphysician providers.

There is a challenge here for antitrust experts as well. There is a need to develop a conceptual framework for determining when antitrust is appropriate, as well as what remedies best serve the public interest. Narrow applications of concepts from other industries may in fact preclude some pro-competitive activities such as direct negotiation between providers and payers which may, in some cases, be appropriate.

Now, this is the conclusion of my prepared remarks. I would be happy, of course, later to expand upon them.

[The prepared statement of Dr. Sloan along with responses to questions asked by Senator Hatch follow:]

Approaches for Reducing Health Care Cost Inflation

by Frank A. Sloan

Testimony Before the Committee on Labor and Human Resources, United States Senate

May 25, 1983

I. Introduction

Thank you Mr. Chairman, and members of the Committee, for inviting me to present my views on options for controlling the rise in health care costs. I am Professor of Economics and Director of the Health Policy Center, Institute for Public Policy Studies, Vanderbilt University. I speak from my experience as a researcher who has devoted most of my professional life to these issues, and as one who has been a consultant to several government agencies and private groups involved in one capacity or another with health care cost containment. Most of my research has been supported by Federal grants from the National Center for Health Services Research and the Health Care Financing Administration.

II. Why Have Health Care Costs Risen So Rapidly?

A number of factors have contributed to the rise in outlays for health care: increased insurance coverage of the type that gives neither patients nor providers an incentive to conserve; demographic changes, especially the aging of the U.S. population; higher prices hospitals, physicians, and other providers must pay for inputs, ranging from personnel, to utilities, to medical equipment; the higher real income of Americans; an increased physician supply, largely the result of concerted efforts by Federal and state governments to overcome a perceived "shortage"; and scientific advances that have greatly improved medicine's ability to diagnose and treat disease but at an increased cost.[1]

There are cost containment solutions associated with most of these causes. Only a few will be considered here.

Lessons from the 1970s

By now, the health care cost crisis is "old news." A number of cost containment initiatives were implemented during the 1970s. Most focused on the hospital where the potential for cost savings seemed the greatest (correctly in my view).

Virtually all states implemented certificate of need (CON) programs during the 1970s. The vast majority of statistical evaluations of CON in particular and health planning efforts in general indicate that this approach holds no promise for health care cost containment. In fact, the chief beneficiaries are existing providers who, at least to some extent, are protected from potential competitors. CON and related programs should be eliminated.

Congress enacted the Professional Standards Review Program (PSRO) in 1972 with the intent of reducing Federal outlays for hospital care. PSROs have also failed in cost containment. For utilization review to be effective, physician reviewers must benefit financially from saying "no." Doctors have this incentive when they are "at risk" for expenses in excess of premium income, when, for example, they are part of an IPA or prepaid group practice. Unfortunately, PSROs offered no meaningful financial incentive. Without this, they serve no useful role in cost containment.

Findings from several recent studies indicate that rate-setting programs implemented by a few states which require hospital participation and compliance have, as a group, achieved cost savings. Between 1971 and 1981, real spending on hospital care per capita population rose at an annual rate of 4.5 percent.[2] Thus, the average annual reduction of 2 to 3 percent attributable to the "average" rate-setting program is consequential.[3]

Several noteworthy particulars, however, lurk behind this general conclusion. None of the programs generated savings during their first two years. Estimates of the "average" influence of rate setting obscure the fact that the programs have not been equally effective. There is some reason to doubt that rate setting would be as successful in states with political climates less conducive to such regulation. The savings is attributable to lower per diem cost rather than to shorter stays or fewer hospital admissions. The programs would be still more effective if specific incentives to curb both types of hospital use were implemented. Thus, although rate setting is a step in the right direction, there is room for improvement.

III. Cost-Containment Programs for the 1980s

The prospective payment plan for hospitals recently enacted by Congress for Medicare gives hospitals an unmistakable incentive to be efficient. It is a tremendous improvement over cost-based, retrospective reimbursement. The new system provides no mechanism for reducing hospital admissions. Although increased admission rates are not a major cause of hospital cost inflation, there is room for additional savings if admission rates can be reduced. Patient cost-sharing is one vehicle for curbing admissions; a fixed rate per patient (capitation) is another.

Governments at all levels pay for more than half of the nation's hospital and a quarter of the physician bill and two-fifths of health care spending overall.[4] With this market share, the public sector has a great deal of leverage. Rather than waste it by dealing with individual providers on a one-on-one basis, when administratively feasible, governments should establish contractual relationships with cost-effective groups of providers with price, a capitation payment, not a charge for a unit of service. In some cases, these contracts may be established through competitive bidding, and in others, by direct negotiation. The experiments with competitive bidding in a couple of Western states are well worth watching. These states are to be congratulated for taking the lead in this area.

Efforts by government to reduce their spending on health care have and will elicit complaints of "cost-shifting" from the private sector. But rather than complain, private sector groups should be encouraged to emulate governmental initiatives and establish their own prospective arrangements and contracts with provider groups. There can and should be a diversity of arrangements. There will be "health care alliances," prepaid group practices, and cost-conscious fee-for-service insurers who, because of cost-monitoring programs, are able to remain competitive.

In no event should governments give in to pressure for rate setting covering all payment sources. How can there be any meaningful competition when, by regulation, everyone pays the same price?

As an interim but second-best measure, Medicare should consider ways to combine hospital and physician payment under the DRG system. A mandatory program of this type realistically faces serious implementation problems.

Government involvement in matters involving private health insurance should, if anything, be curtailed. For various reasons, it is inappropriate for government to dictate the type of coverage private employers should provide.

The tax subsidy of private health insurance purchases should be reduced. By lowering the price of insurance, the subsidy encourages employees to demand first-dollar coverage. The subsidy is objectionable on equity grounds because it primarily accrues to the upper middle and upper classes. With the Federal deficit at its current level, the substantial revenue loss attributable to this subsidy is regrettable. If Congress does not wish to raise taxes, it should reduce the subsidy, thereby broadening the tax base and permitting further reductions in marginal tax rates.

A frequent criticism of the "tax cap," which limits the amount of the premium contribution excluded from personal income taxation, is that there is no "hard" evidence that limiting the subsidy will cause the public to eschew first-dollar coverage and shop for insurance that yields best value for the premium dollar. Given the current state of knowledge, no one can guarantee that this will happen. But to the extent the people choose to continue purchasing complete coverage, this will at least provide an indication that this is the type of protection people want. Perhaps we are misreading the public; they may be willing to devote a still higher percentage of Gross National Product to health care. In any case, the other benefits to be derived from the tax cap, mentioned above, would apply.

Finally, there is a need to maintain antitrust enforcement in the health field. To the extent that competition among alternative delivery systems will become more widespread, there will be attempts to deny innovators access to hospitals, more sophisticated group boycott activity, and there will be disputes involving payment to nonphysician providers.

There is a challenge here for experts in antitrust as well. There is a need to develop a conceptual framework for determining when antitrust is appropriate as well as what remedies best serve the public interest. Narrow application of concepts from other industries may in fact preclude some pro-competitive activities, such as direct negotiation between providers and payers.

References

1. For further elaboration and quantification, see Frank A. Sloan and William B. Schwartz, "More Doctors: What Will They Cost? Physician Income as Supply Expands," Journal of The American Medical Association, Vol. 249, No. 6, February 11, 1983, pp. 766-9.
2. Daniel Waldo and Robert Gibson, "National Health Expenditures, 1981," Health Care Financing Review, Vol. 4, September 1982, pp. 1-35.
3. For further details, see Michael Morrisey, Frank Sloan, and Samuel Mitchell, "State Rate Setting: An Analysis of Some Unresolved Issues," Health Affairs, forthcoming.
4. Waldo and Gibson.

1. Dr. Sloan, would you describe what our system would be like under nationalized health insurance plans?

First, as the question implies, there are a variety of alternative nationalized insurance plans. Some deal with financing only, others involve major interventions in the production of health care services. If the current financing system were extended to the U.S. population as a whole at this time, health care cost inflation would undoubtedly accelerate. There would then be widespread demand for stringent controls over all aspects of the health care system.

Outright government ownership or strict government controls imposed on a privately-run system could indeed reduce the growth of health care expenditures. This would be a benefit, but there would also be costs.

Benefits of a nationalized system with stringent regulatory controls:

A. Less would be spent on health care.

B. The poor would be better off (receive more services in absolute terms and their share of total medical services would increase). This has been the experience in industrialized countries, such as the U.K. and even Canada. A nationalized system would remove financial barriers to care such persons now face.

Costs of a nationalized system with stringent controls:

A. The rate of technological change would be greatly reduced. Some experts argue that there is now "too much" innovation, but would these same persons be satisfied with little or no innovation? Currently, other countries can borrow new technology from the U.S., which is the leader in medical research and development. Which country will provide this role when the rate of return to investment in medical R and D is insufficient to attract investment? It is doubtful that public sector financing of R and D could completely fill the gap.

B. Allocation of capital budgets would be a government responsibility. Capital expenditures would be controlled, but it would probably be difficult for communities with a rapidly increasing population to secure funds for construction. Location of new facilities would become a political issue. There would be much less equipment. For example, the U.K. has a fraction of the CT scanners we do in the U.S.

C. The nonpoor would be no better off and frequently worse off. If the poor secure a larger share of a fixed pie, the nonpoor must receive less on average. The reallocation would be accomplished by queues of various types--longer waits in doctors' offices, increased delays to an appointment, and waiting lists for admission to a hospital or nursing home. The queues could be eliminated by increasing capacity, but then the amount spent on health care would necessarily rise.

To keep the health care budget under control, government would have to make some tough decisions about treatment of high cost illness. Such open-ended financing programs as the End-Stage Renal Disease Program would probably be dropped. Specific criteria would be developed to determine eligibility for kidney dialysis and transplants.

D. Providers, especially physicians, would be worse off. Fees would be set by government if, in fact, fee-for-service medicine were maintained. Salaried practice could become the dominant practice form. Provider income would almost certainly fall. Practice location would be constrained by the slots available for physician practice in the community. It is interesting to note, however, that doctors in the U.K. have maintained a high degree of clinical freedom, subject to the constraints of tight operating and capital budgets. Therefore, I suppose doctors would retain some autonomy in clinical matters.

2. In your testimony, you describe public sector initiatives in certain Western states that are establishing contracts with providers with competitive bidding. Which states are doing this and can you elaborate on their effects?

The two states are California and Arizona.

In California, the Private Insurance Contracting Reform Acts established a Selective Provider Contracting Program that covers hospitals' Medi-Cal inpatients. The legislation was passed in July 1982. It authorizes the head of Medi-Cal to negotiate contracts with hospitals, and Medi-Cal patients in the selected cities must go to the hospitals with the contracts. The contracting hospital must accept all Medi-Cal patients who come to it. The hospital cannot maintain separate facilities for these patients. It is required to grant staff privileges to any doctor who wishes to admit Medi-Cal patients to the institution.

Medi-Cal negotiates a flat per diem rate with the contracting hospital. There is no casemix adjustment. Although hospitals cannot reject complicated cases, they can try to boost length of stay.

It is much too early to tell whether the program will in fact generate substantial savings and what the impacts on access and quality of care will be. The first contracts just went into effect earlier this year. But there has been a lot of reluctance on the part of hospital officials around the country about competitive bidding, and the ice has been broken in California. For some reason, HCFA has not yet initiated a study of the new system in California. The Arizona program involves competitive bidding in six different categories, including the indigent, the disabled, and state employees. In Arizona, the bid is on capitation rate rather than on a unit of service (such as the hospital day in California). A group may bid to provide hospital care only, but preference is given to bids which include a comprehensive range of services. Up to now, there has been substantial variation in the rates bid. The variance is likely to decrease as bidders gain familiarity with the process and determine the capitation rate necessary to cover cost with greater certainty. HCFA has initiated a study of this program.

My source of information on the Arizona program is:

Professor Ronald J. Vogel
Department of Management and Policy
College of Business and Public Administration
University of Arizona
Tucson, Arizona 85721

He gave me the following reference:

State of Arizona Department of Health Services, "Arizona Health Care Cost Containment System--AHCCS: A Statewide Approach to Cost Effective Health Care Financing," Vol. 2 and Appendices, Phoenix, Arizona, May 1982.

3. Have increased regulations contributed to health care cost inflation? And what would further regulations do to our current market?

As I believe I indicated at the hearing, I just completed statistical work on a study which indicates that, as a group, capital-facilities regulation, utilization review, and rate controls added to hospital cost inflation observed between 1970 and 1980. (I still need to write up these results.)

The behavior of the group, however, obscures within-group variation. Certificate of need and PSROs have done nothing to reduce the growth of hospital costliness. In fact, if anything, they have increased it. On the other hand, mandatory rate control programs which have been implemented by a few states did reduce the annual growth in hospital expenditures by some 2 to 3 percentage points, after they had been in effect for a few years. I have written about this in two articles which should appear any day now, one in Milbank (I am the sole author) and another in Health Affairs (with Michael Morrisey of the American Hospital Association and Sam Mitchell of the Federation of American Hospitals).

Thus, based on the experience of the 1970s, the only program to emerge which holds any promise for cost containment is state rate-setting. There is some question whether the favorable experience from such states as New York, New Jersey, and Massachusetts can be replicated in other states with different political environments. Moreover, the long-term adverse side effects of such programs is not well-understood.

As in the past, the effect of further regulation depends on the type of regulation that is implemented. Even though there are some favorable results from the past on hospital rate-setting, I would hope that policymakers would not completely rely on this regulatory option. Prospective rates should be established for the public programs, but government should not direct the reimbursement practices of private payers. An all-payer rate-setting program would for all practical purposes preclude price competition in this industry.

4. Are there current federal barriers, or state and local barriers, to encourage competitive bidding and PPO's?

To my knowledge, there has not been a study of this issue, but the following are likely barriers.

All-Payer Rate-Setting--If there is a uniform price for hospital care, there cannot be price competition. In principle, PPOs can be exempted from all-payer price controls, but it is not clear how these exemptions work in practice.

Certificate-of-Need--CON is one tool traditional providers have for blocking entry of innovators. Applications for new facilities and major equipment from hospitals affiliated with PPOs are likely to be targets for the "ins" when PPO hospitals come up for CON review.

State Insurance Statutes--There are state laws that prohibit insurers from varying the amount they pay individual providers. Thus, a given insurer is required to pay the same to Hospital A as to Hospital B even if it could negotiate a more favorable rate with B. Also, freedom of choice laws prohibit insurers from influencing a patient choice of providers. It is not clear that such laws have hindered the development of PPOs to date, but they could become meaningful barriers as the PPO movement spreads to states less receptive to a PPO concept.

Antitrust Policy--There is some question concerning the antitrust vulnerability of horizontal arrangements between providers establishing PPOs. Unfortunately, I do not know much about this area.

Medical Practice Acts--A PPO has some reason to be concerned about the mix of personnel used in its facilities. Licensure laws may prevent delegation of tasks even when the risk to the patient is slight or nonexistent. I do not oppose licensure, but these laws merit scrutiny for their anticompetitive impacts.

5. You state in your testimony that health planning laws should be eliminated. How then should capital expenditures and allocation of resources be dealt with under a health care cost strategy?

To the extent that too much has been spent on hospital and nursing home facilities, the third party reimbursement system is largely to blame. Retrospective cost reimbursement has allowed providers to build and then pass the high average cost associated with low capacity utilization along to the public. Retrospective charge-based reimbursement is not much better; charge payers consider almost any charge to be "reasonable."

Health planning and certificate of need attack the symptoms rather than the cause of the problem which is the nature of the current third party reimbursement system. Under a prospective payment system, which encompasses capital costs, the provider is at risk when he makes investments in plant and equipment. If capacity utilization is low, the provider may go broke.

Congress has instructed the Department of Health and Human Services to devise a prospective payment plan for Medicare which includes payment for capital. Such a plan should discourage "unnecessary" investment.

A hospital involved in HMOs or PPOs has to exercise care in its capital expenditures policy. If it spends too much, the hospital will not be competitive in HMO or PPO markets.

Reimbursement reform alone should do the job of controlling capital expenditures. Congress has been concerned about the rising health care cost and therefore has been reluctant to abandon health planning. My evidence shows planning has been ineffective, but this argument is hard to sell with the current rate of health care cost inflation.

Therefore, one possibility would be to exempt an institution from certificate of need review if it can show that at least half of its patient revenue is derived from prospective payment sources and/or from financing other than standard fee-for-service (HMOs, PPOs, etc.).

Your choice of the word to "allocate" resources brings up another point about health planning. The planner is a "nay-sayer." He does not have a capital budget to build a facility in an area of high need. So his present role as an allocator is quite limited.

The CHAIRMAN. Thank you, Dr. Sloan. We appreciate that. We will put your complete remarks in the record, as we will for all witnesses today.

Dr. Reinhardt, we will turn to you.

STATEMENT OF UWE E. REINHARDT, PH. D., PROFESSOR OF ECONOMICS AND PUBLIC AFFAIRS, PRINCETON UNIVERSITY

Mr. REINHARDT. Thank you, Senator Hatch, and your colleagues on this committee, for inviting me to comment on approaches to cost containment in health care.

Before doing so, I do want to register a disclaimer, an analogue of the truth-in-lending law of banking. I would call it the truth-in-testifying law, and it is this:

Senator KENNEDY. It will be unusual. [Laughter.]

Mr. REINHARDT. It is almost impossible for an economist to give policy advice in health care without packaging into that advice his or her own ideology. Therefore, I will not proffer, normative advice. I would rather like to present to you some data and some tradeoffs, and then let you think about them.

For example, if one looks at the issue of health care costs, and if one defines it to be a problem—I personally do not define cost to be a problem, as I state in the concluding part of my paper; but supposing I accept the verdict that it is a problem—then there are, indeed, two distinct strategies we could use to constrain costs.

One is a fully comprehensive national health insurance system, and the other one is a price-competitive system.

A fully comprehensive national health insurance system relies primarily on administrative devices to control utilization, prices, and thereby costs. A price-competitive system relies primarily on prices and private household budgets to do these tradeoffs and to control costs.

The overall expenditures could be literally fine-tuned to be the same. It is the incidence of the burden that would be different. As I put it in on page 4 of my statement: Let me hasten to add that I am not now advocating the introduction of national health insurance in the United States. That may be neither politically nor technically feasible at this time. I merely wish to acknowledge than an NHI plan could be used as a cost-containment strategy if we wanted to constrain costs.

Whether or not one favors national health insurance or the price-competitive strategy is ultimately a matter either of economic self-interest or simply of taste. A near-poor American, for example, a gas station attendant or an unemployed worker, would surely fare better under, say, the Canadian health insurance system than he does in the United States.

As an economist who, like most of his colleagues, finds himself in the upper 5 to 10 percent of the Nation's income distribution, I share with my colleagues a certain bias toward price-competitive markets in which my own social class tends to fare so well. The choice between NHI and a market-oriented system is as simple and as political as that.

Now, you may ask: How can I say that national health insurance is not inherently inflationary? After all, economic theory states that, if Jane and John Doe pay little or nothing for a commodity at point of service, they will consume too much of that commodity and they will not even care what price producers charge third-party payers.

The policy implication of this theory is simple: Make Jane and John Doe pay more of the cost of the commodity, and they will consume less of it and bargain over its price.

Now, as a card-carrying economist, I am obliged by long mental conditioning to endorse this theory. However, every so often the world is impudent to us economists by producing data that fly in the face of the theory.

First of all, it is simply a myth that health insurance coverage in America is complete. It is not. I would like to draw your attention to figure 5 of my statement, page 2-b. Currently, one-third of all health care expenditures in this country are still paid by patients at point of service. That is an overall average. However, if you look at ambulatory physician care you will note that 60 percent of that on average is still paid out of pocket. If I look at dental care, that is closer to 80 percent. If I look at eyeglasses, repair of glasses and contact lenses, 91 percent is paid out of pocket; medical appliances and supplies 79 percent; and drugs, I think, is something like 80 percent.

I cannot understand how so many of my colleagues claim that America is overinsured. Just what do they mean by that term?

Hospital care is more or less fully insured. If there is a problem with over-insurance in America, it must lie in that sector, in which case the hospital is then the enemy that should be targeted for a cost-containment strategy.

A second piece of data that troubles one as an economist is that, in international comparisons, one does not find the predicted correlation between cost sharing and the percent of GNP that goes to health care. In this connection, I would refer you to figure 6, page 2-d, of my statement. I defy anyone to find me a strong simple (first-order) positive correlation there between cost sharing and health care expenditures.

To be sure, for a fee a skillful econometrician could probably find a partial correlation comparable with our preconceived notion. My own interpretation, however, is that figure 6 shows the cost-constraining influence of the administrative devices that become feasible under a NHI program. The other nations—for example, Canada—spend less on health care than we do. They use administrative devices to constrain costs. Germany in recent years, with full health insurance coverage, has done this through negotiation. Between associations of health insurers and associations of providers. Germany has in the last few years controlled health care expenditures fairly well in this fashion.

The upshot of my remarks is that, if a Nation does have the courage to accompany national health insurance with the proper cost-control devices, it can control the growth of expenditures reasonably well.

Now, it is also true we could use the alternative strategy, which is the price-competitive one. Here I would refer you to table 2, page 3-a, of my formal statement.

If we ask ourselves, "What would we like a health insurance system to do?" I can think of three goals. First, it should distribute health care equitably—that is goal one. It should, secondly, not interfere in the freedom of providers to practice medicine as they see fit and to price their services as they see fit. That would, in the abstract, be a desirable goal. Third, there should be budgetary control. That goal numbers three.

Now, it is my belief, having studied this problem for over a decade, that ever since man's fall from grace, God has so arranged the world that you can reach at most any two of these goals, but not all three. [Laughter.]

We tried, in the early part of the 1970's, to attain an egalitarian distribution of health care and yet grant providers total freedom to practice and price as they saw fit. The result was predictable. The third goal, budgetary control, was not achieved. We threw away the key to the treasury.

We could have gone into row two of table 2 and converted to a national health insurance system. Then we would take away the providers' complete freedom to practice medicine as they see fit and to price their services as they see fit, but we might have attained both the goals of equity and of budgetary control.

Or, lastly, we could go the third route, that is, to preserve the freedom for providers to price as they see fit, to preserve the hospitals' freedom to do what they want—for example, to put capital in place as they see fit and to price their services as they see fit—but then we must abandon the egalitarian precepts that this Nation professes to observe in health care.

This, then, unfortunately, is the choice that I believe you face in Congress: It is a tradeoff between freedom for providers, on the one hand, and equity in the distribution of health care, on the other. If you want freedom for providers under a price-competitive health insurance system, you must openly countenance two-tier health care in America. Of course, we have it now two-tier health care now, but that is inadvertent. My point is that you must officially countenance two-tier health care. If you do not have the courage to countenance two-tier health care in America, you ultimately must interfere in the freedom of providers to price as they see fit. Is there any other way?

As I remark on page 4 of my final statement "it is arrogant for economists to pretend that our politicians are not aware of the role financial incentives could play in health care. Our politicians know this only too well. What our politicians seem to lack is not analytic insight on this point but rather the courage to act upon the tradeoffs clearly before us," and this is the agonizing tradeoff I am talking about. If you want one-tier health care you must interfere with providers. If you do not wish to interfere with providers and if you wish to use prices as a rationing device, you must countenance two-tier health care. There is no escape from that dilemma. Incidentally that is why my profession is called a dismal science: we are obliged to remind others of uncomfortable trade-offs.

In the final part of my formal statement—I will not dwell on it here—I raise the guestion why we consider health care expenditures as a treat to the American people. I put it there as follows: Suppose Dan Rather, one fine evening, went on the news with the following item: "Government spokesmen today pointed to increased consumer spending on automobiles as signs of economic health. The only troublesome portent, they add, is that spending on health care increased as well."

Would you be shocked by such a news report? You might be. Why is an expenditure on automobiles good for the Nation and an expenditure on a hospital stay bad? I think I could give you some conceivable explanations, but occasionally it is useful to ask yourself just why we constantly blast a sector that has been the main source of employment in the 1970's, that has provided entry into the labor force for women and minorities, and, incidentally, has done much for "Reaganomics"—because where would Reaganomics have been without the powerful health care locomotive?

Table 3 of my formal statement indicates that even if we continued to spend 13 percent per year on health care from here to the year 2000, and GNP grew by only 9 percent per year, that would still not drive us into the poorhouse—as unbelievable as that may seem. Although, in the year 2000, 21 percent of the GNP would then go to health care—we would spend $3.3 trillion on health care—the nonhealth care GNP in real terms per capita would still be 33 percent higher than it is now. We could still each have a Perdue chicken in every pot, plus a basement full of video games, plus this enormous health care bill. If we wished, we could afford it. Whether we should is, of course, a matter of taste. But as Julius Caeser said, "De gustibus non disputandum est" (There is no accounting for taste). [Laughter.]

Thank you.

[The prepared statement of Dr. Reinhardt follows:]

PREPARED STATEMENT OF UWE E. REINHARDT, PH. D., PROFESSOR OF ECONOMICS AND PUBLIC AFFAIRS, PRINCETON UNIVERSITY, PRINCETON, N.J.

My name is Uwe E. Reinhardt. I am a Professor of Economics and Public Affairs at Princeton University, Princeton, New Jersey. Much of my research during the past decade has been devoted to health services research and the analysis of health policy.

I would like to thank you, Senator Hatch, and your colleagues on this Committee for inviting me to comment on approaches to cost containment in health care.

There can be no question that the health industry has been one of the nation's fastest-growing sectors in the economy during the past decade and a half. As Figure 1 indicates, the annual growth in health care expenditures has generally outpaced the overall growth in GNP. This trend continues apace. Health care expenditures now account for about 10 percent of total national output. Although other nations also have registered sharp increases in these outlays (see Figure 2), it is the case that few nations spend a higher proportion of their GNP on health care than does the United States (see Figure 3).

In what follows I would like to focus on the following questions concerning this rapid growth in health expenditures, namely:

A. What has been the driving force behind the growth in health care expenditures?

B. What are our policy options, should it be decided to constrain further growth in health care expenditures?

C. In what sense do health-care expenditures actually constitute an economic problem in the first place?

A. The Driving Force Behind Health Care Expenditures

It has become customary in this country to attribute the secular growth in health expenditures to a parallel growth in health insurance coverage. The economic theory underlying this view is simple: If Jane and John Doe pay little or nothing for a commodity at point of service, they will consume too much of that commodity and they will not even care what price producers charge third-party payers. The policy implication of the theory is equally simple: Make Jane and John Doe bear more of the cost of the commodity, and they will consume less of it and bargain over its price.

As a card-carrying economist who has been properly conditioned in the beliefs of his profession, I am obliged to endorse this thesis and also the policies that flow from it. There is, after all, the multimillion dollar Rand Corporation experiment that demonstrates the empirical validity of the thesis within the context of health care.[1] Even so, from time to time I come across

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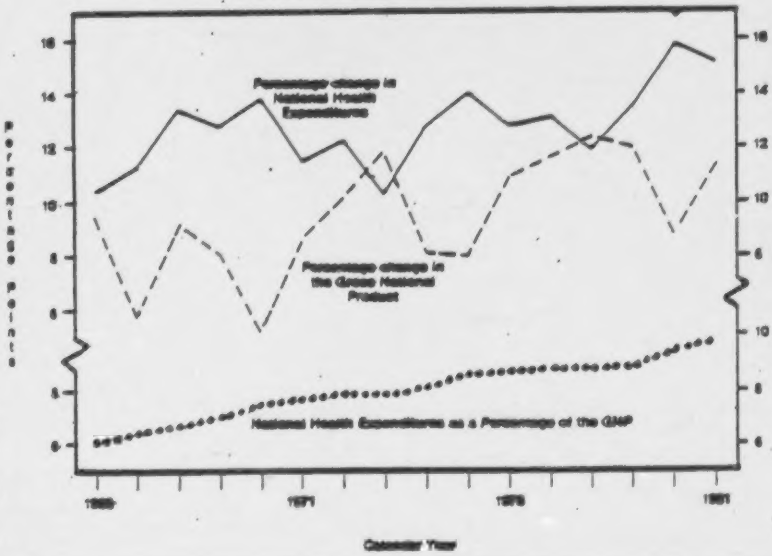
[1] See Joseph P. Newhouse, et al., Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance. Rand Corporation Publication No. R-2847-HHS. Santa Monica, California: Rand Corporation, Jan. 1982.

FIGURE 1

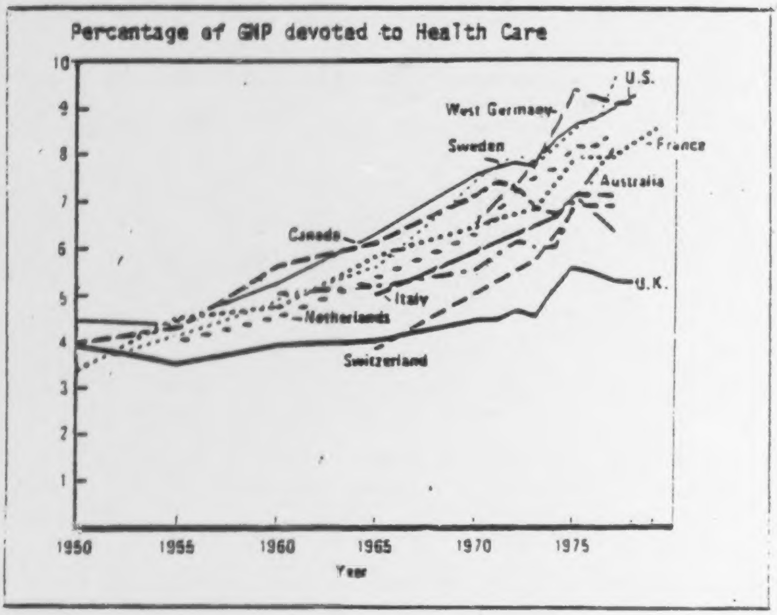
National Health Expenditures and Gross National Product: Growth and Relative Sizes, 1965-1981



SOURCE: R.M. Gibson and Daniel R. Waldo, "National Health Expenditures, 1981", Health Care Financing Review, September, 1982, p.3.

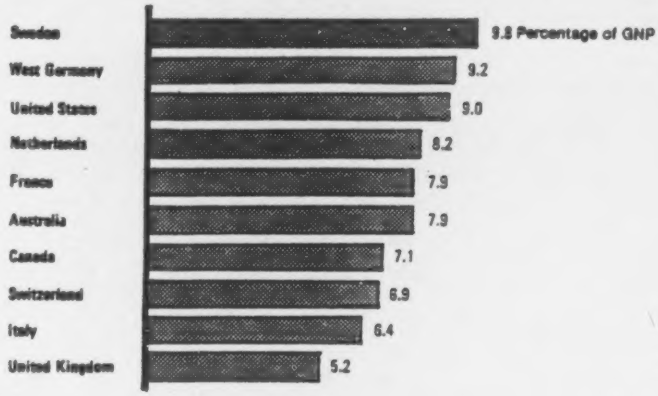
FIGURE 2

SECULAR GROWTH IN HEALTH CARE EXPENDITURES

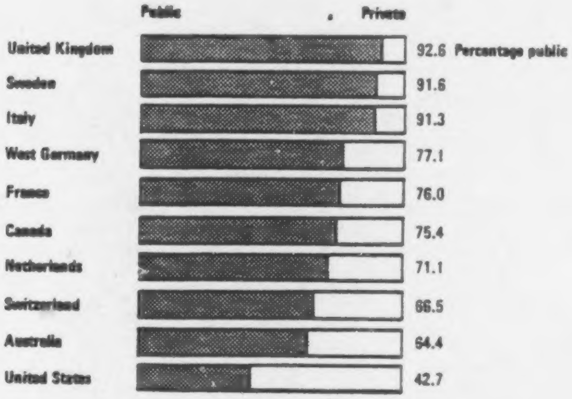


SOURCE: R.J. Maxwell, Health and Wealth, Lexington Books, 1981, p. 44.

FIGURE 3
INTERNATIONAL COMPARISON OF HEALTH EXPENDITURES



Total Health-Care Expenditures (Public and Private) as a Proportion of GNP in 1977



Sources of Finance for Health-Care Expenditures: The Mix between Public and Private in 1975 as a Percentage of Total

SOURCE: R.J. Maxwell, Health and Wealth, Lexongton Books, 1981, figures 3-5 and 4-1.

data that raise some *caveats* in my mind.

First, it is simply a myth that health insurance coverage in this country is complete. On the contrary, very few nations on earth impose as much cost sharing on patients as does the United States. Although there has been growth in insurance coverage during the past several decades, American patients still pay an average of close to one-third of all health care expenditures out of pocket directly at point of service (see Figure 4). The extent of cost sharing varies considerably by type of service. Roughly 60 percent of outlays on ambulatory physician care is still out of pocket at point of service (see Table 1). The percentages for dental care, drugs, eyeglasses and medical appliances are even higher (see Table 1 and Figure 5). Only hospital care is now covered more or less completely; but that sector accounts for only about half the health care dollar.

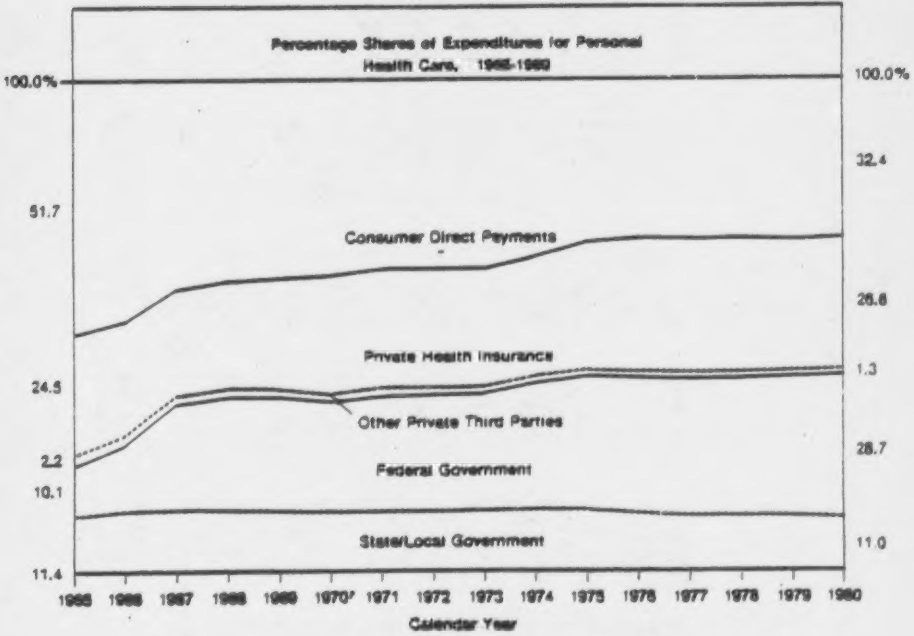
In other words, if the solution to our cost problem is a return to price-competitive markets, we are already half there! In fact, we have always been there. There remains only the hospital sector whose services are now more or less fully covered by health insurance and which could be opened to market forces through greater cost sharing by patients.

A second circumstance that gives me pause is the rather poor correlation between cost sharing and health expenditures one observes in cross-national comparisons. Figure 6 illustrates this point. Paradoxically, while the United States exhibits one of the highest degrees of cost sharing by patients, it also exhibits one of the highest ratios of health care expenditures to GNP. To be sure, a bivariate correlation may be misleading. After control for other factors that influence health spending a skillful economist might well unearth the expected negative partial correlation between cost sharing and health expenditures. On the other hand, it may just as easily be the case that truly national health insurance systems incorporate economic and administrative control devices that make it relatively more easy to constrain health care expenditures than is possible in the highly decentralized American system. The much-mouthed folklore that national health insurance systems are inherently more inflationary than the present American system strikes me as unsubstantiated. It flies in the face of the available data.

To the extent that health insurance coverage in this country has indeed contributed to the secular growth in health care expenditures, the culprit is unlikely to have been the consumer's behavior alone. Just as significant -- and perhaps even more so -- has been the practice of reimbursing hospitals on a retrospective full cost basis and of compensating physicians on the basis of so-called "usual, customary and reasonable fees." In fact, I am not aware of any country in which health care providers enjoy quite the freedom to set prices as they do in the United States. Most other countries pay providers on prospectively set per diems or global budgets, and on negotiated fee schedules that bind the individual practitioner.

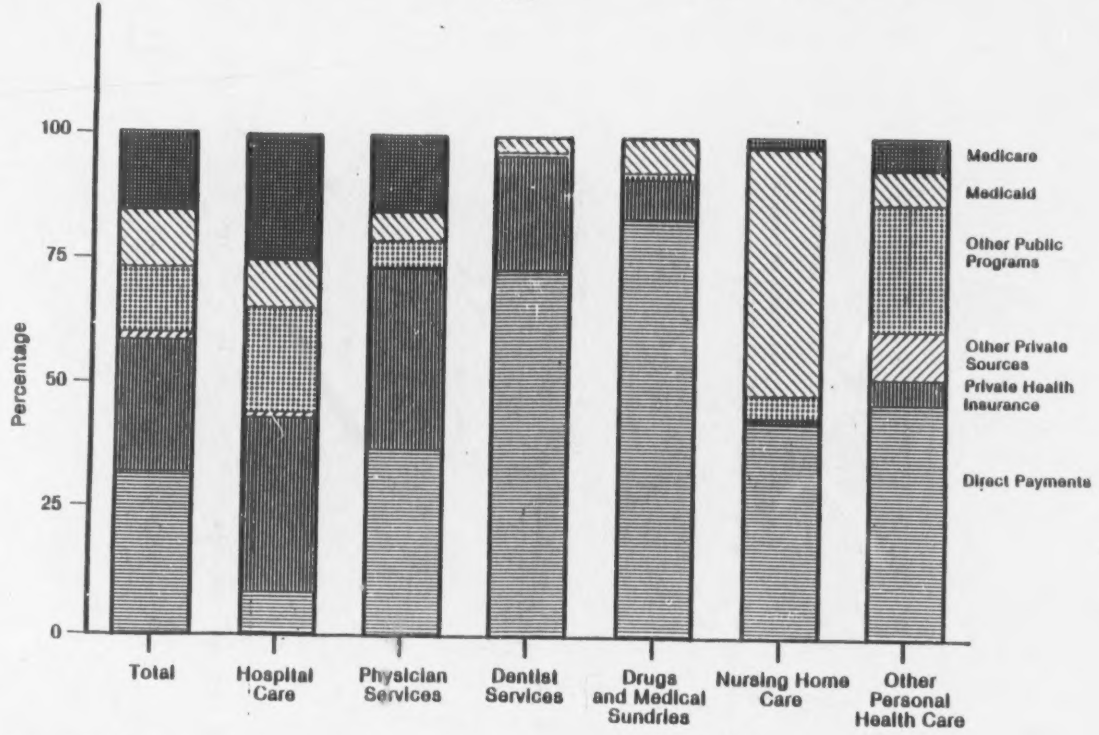
Any truly serious attempt to come to grips with the problem of health care expenditures must either curtail the providers' freedom in this area or, alternatively, abandon the egalitarian precepts on which this nation had sought, of recent, to base the distribution of health services. Table 2 illustrates this proposition.

FIGURE 4



__SOURCE__: Robert M. Gibson and Daniel R. Waldo, "National Health Expenditures, 1980", __Health Care Financing Review__, September 1981, p. 6.

FIGURE 5
Sources of Funds for Personal Health Care Expenditures, by Type of Expenditure
1979



Source: Tables 3 and 5

SOURCE: Robert M. Gibson, "National Health Expenditures, 1979", Health Care Financing Review, Summer 1980, Volume 2, No. 1, p. 14.

TABLE 1

PERCENTAGE OF HEALTH EXPENDITURE
PAID OUT OF POCKET

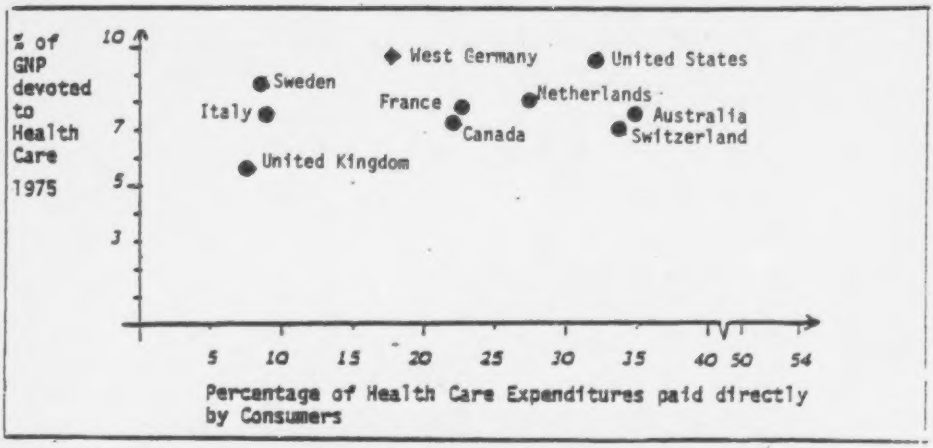
(SAMPLE OF 14,000 U.S. FAMILIES)

TYPE OF SERVICE	FAMILY	THIRD-PARTY (INSURANCE, ETC)
1. Ambulatory Physician Care	59%	41%
2. (All Physician Services)	34%	66%
3. Dental Services	80%	20%
4. Prescribed Medicine	80%	20%
5. Repair of Glasses and Contact Lenses	91%	9%
6. Medical Appliances and Supplies	79%	21%
7. Inpatient Hospital Services (exc. physician care)	12%	88%

SOURCE: Kasper, et. al. (1980), "Expenditures for Personal Health Services." Finding from 1977 National Medical Expenditures Survey. Mimeographed paper, presente at the American Public Health Association meetings, 1980.

FIGURE 6

HEALTH CARE EXPENDITURES AND COST SHARING



SOURCE: Adapted from Martin Pfaff, Finanzierungs- und Ausgabenstroeme im Gesundheitssektor: Eine realtypische Betrachtung Fiskalischer Systeme. Mimeographed monograph, Bamberg, West Germany, 1982, Figure 5.11, page 100.

Shown in the left three column headings in Table 2 are several features one would like to see incorporated in a nation's health care system. These desiderata are that

1. the distribution of health services should be equitable;
2. the providers of health services should be allowed to practice and to price their services without government interference; and
3. the sector should facilitate budgetary control and and efficiency in the allocation of resources.

It appears that, ever since the fall from grace, mankind has been prevented from attaining all three goals at once. We must trade off among the goals, uncomfortable as that may be.

It is my proposition that the chief cost driver in American health care has been our lack of courage to face up openly to the trade-off among equity in distribution, freedom for providers and budgetary control. Furthermore, I fear that because of our timidity in this respect we are permitting our health care system to slide toward a state that can only be judged disgraceful by international standards. In that state the economically fortunate will fare well, while the uninsured working poor and unemployed suffer indignities and fiscal agony, if not outright lack of appropriate medical care.

During the late 1960's and early 1970's, we sought to attain an equitable distribution of health care without in the least impinging upon the providers' economic freedom. The preservation of that freedom can be viewed as a bribe paid for the providers' acquiescence to the Medicare/Medicaid programs. The implicit social contract found explicit expression in the open-ended reimbursement methods adopted for these government programs. We chose row 1 of Table 2. The result was a providers' dream world devoid of any effective budgetary- and cost-control. Our health care budgets predictably exploded.

The providers' dream, alas, could not last forever. It is just too expensive. In abandoning it, the nation could go but one of two ways: it could adopt a full-fledged comprehensive national health insurance system (row 2 of Table 2) or a market-oriented, price-competitive system (row 3 of Table 2). Under a national health insurance system one generally seeks to preserve an egalitarian distribution of health care by sacrificing the providers' economic freedom. Under the price-competitive strategy one chooses just the opposite.

In a sense, then, the crossroads at which the nation found itself in the mid-1970's -- and finds itself still today -- implies a trade-off between equity in the distribution of health care and economic freedom for providers. Our national health policy will get nowhere unless we muster the courage to face up to this trade-off. That policy will remain as confused and impotent as it has been unless we make that dismal choice, regardless of the hundreds of neat financial tricks economists discover in their little tool kits.

TABLE 2

COMPETING OBJECTIVES IN HEALTH CARE: BASIC PROTOTYPICAL SYSTEMS THAT SPAN THE SET OF ACTUAL SYSTEMS

-DESIDERATA-			
EGALITARIAN DISTRIBUTION	FREEDOM FROM GOVERNMENT INTERFERENCE IN PRICING AND IN THE PRACTICE OF MEDICINE	BUDGETARY AND COST CONTROL	PROTOTYPICAL SYSTEM
YES	YES	NO	THE HEALTH-CARE PROVIDER'S DREAM WORLD
YES	NO	YES	A NATIONAL HEALTH INSURANCE SYSTEM WITH FEE SCHEDULES AND OTHER UTILIZATION REVIEW BUDGETARY CONTROLS. (E.G., CANADA, WEST GERMANY)
NO	YES	YES	A PRICE-COMPETITIVE MARKET SYSTEM

⇔ THE TRADE-OFF WE FACE

It is arrogant for economists to pretend that our politicians are not aware of the role financial incentives could play in health care. Our politicians know this only too well. What they seem to lack is not analytic insight, but rather the courage to act upon the trade-offs clearly before us. The challenge in the 1980's will be to muster that courage, at long last. Thereafter the implementation of the economist's tricks will be comparatively easy.

B. The Policy Options Before Us

As noted, if we are intent on constraining the future growth in health care expenditures, we could do so either by adopting national health insurance (NHI) or, alternatively, by embracing a price-competitive approach even for hospital care.

Attempts to introduce national health insurance were made throughout the last decade, and they failed. The argument at the time was that such a program would be insufferably inflationary. That prediction is, as I have stated, not substantiated by the available data. On the contrary, a national health insurance program confronts the providers of health care with sufficient market power to constrain health care expenditures, as Canada, France and West Germany have shown. The real opposition to national health insurance came not from those who feared a cost explosion but, rather, from those who thrive on cost explosions -- the providers of health care. By dividing and ruling as they can in our mosaic of small health insurance plans, they fare far better than they would under a comprehensive NHI.

Let me hasten to add that I am not advocating the introduction of a national health insurance plan in the United States today. That may be neither politically nor technically feasible at this time. I merely wish to acknowledge that an NHI plan could be used as a cost-containment strategy if we were bent on such a strategy. Whether or not one favors NHI or the price-competitive strategy is ultimately a matter either of economic self-interest or simply of taste. A near-poor American -- e.g., a gas station attendant or an unemployed worker -- would surely fare better under, say, the Canadian health insurance system than he does in the United States. As an economist who, like most of his colleagues, finds himself in the upper 5 to 10% of the nation's income distribution, I share with my colleagues a certain bias toward a price-competitive market in which my own social class tends to fare so well. The choice between NHI and a market oriented system is as simple and as political as that.

The demise of any prospect for NHI has now moved us into the bottom row of Table 2 -- into a price-competitive system. In my view, such a system inevitably implies two-tier (really, multi-tier) health care. One can imagine many types of two-tier systems, however, and some of these are more humane than others.

The least humane system would be a price-competitive system coupled with the myth that America delivers one-tier health care. From the viewpoint of political cosmetics, such a system has a certain appeal. But such a system would balance its books simply by eclipsing some members of society from the marvelous single tier altogether. Clearly, a fake one-tier system of this sort would, in effect, be brutally two-tiered. Unfortunately, we now seem to be sailing toward precisely such a system.

A more humane two-tiered system would be one in which the public sector purchased carefully defined, good-quality care for publicly insured patients from a set of selected providers chosen either on a price-competitive basis or through negotiation, leaving the rest of society to fend for itself. By abandoning the attempt to couple the Medicare/Medicaid programs to the so-called free market system and to offer the insured completely free choice of providers, the government would at long last gain the freedom to act as a prudent purchaser and to control its own health care budgets. Choice-constrained systems of this sort are beginning to emerge at the state and local level -- e.g., in Arizona or in New York. They should be adopted at the federal level as well.

C. Are Our Health Care Expenditures Really Too High?

So far I have tacitly accepted the widespread notion that our health care expenditures are too high. At the risk of seeming impudent, I would at least like to raise the question just how we have arrived at that conclusion. Put another way, the question arises just what percentage of GNP our nation should devote to health care.

An extended discussion on this point would lead too far afield; I have presented it elsewhere.[2] To get a flavor of the argument, however, suppose that one fine evening, Dan Rather appeared on the evening news with the following item:

> Government spokesmen today pointed to increased consumer spending on automobiles as signs of an economic recovery. The only troublesome portent, they add, is that spending on health care increased as well.

Would you be startled by such a report? You should be, for it seems self-contradictory. What is so good, one may ask, about added expenditures on automobiles which will pollute the environment, add to the carnage on the highways and increase our dependency on foreign oil? What is so bad about the provision of some added physician visits or patient days in the hospital? Is the answer self-evident? I think not.

From a strictly macro-economic perspective we should, perhaps, accord our health care sector accolades. That sector was an important source of jobs during the 1970's, offering especially women and members of minority groups an entree into the labor force. Although beleaguered members of the current Administration are visibly vexed by the recent growth in health care expenditures, they might ask themselves just how much more dismal their economic record would have been in the past two years without the pull of the powerful health-care locomotive.

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[2] See U.E. Reinhardt, "What Percentage of the GNP Should be Spent on Health Care", forthcoming in Leaders (and available in mimeographed form from the author).

Now it may be and has been argued that health care expenditures crowd out capital formation -- that whatever short-term macro-economic cosmetics added health care expenditures may yield, they place a long-term mortgage on our future. The argument is both valid and unpersuasive. Granted, there is a worldwide shortage of savings. That shortage is particularly acute in the United States. Its elimination will require a cutback in the percent of GNP absorbed by consumption. But why, one must ask, should we single out health care as the sacrificial lamb? Why not cut back on automobiles, on fashion, on junk food or on the videogames now befogging our childrens' minds? Until 1973, Americans collectively spent more on alcohol and tobacco than on hospital care. We spend $65 billion on these two items now. Would not they be more logical targets of a consumption-containment policy? Besides, can anyone seriously argue that all health care expenditures represent consumption? Consider the ever-growing number of babies born out of wedlock in the United States. Would any straight-thinking person regard public outlays on their health care consumption? By and large it is not. It is a highly productive investment in human capital.

It may be argued, next, that while current levels of health care expenditures may not yet constitute a macro-economic threat, sustained further growth in these expenditures in excess of the growth in GNP would sooner or later drive us into the poor house. That folklore also can be questioned. Table 3 speaks to this issue.

Table 3 shows the percentage of GNP that would be absorbed by health care in the year 2000 if nominal GNP grew by 9% per year until then, but health care expenditures grew by either 9%, 11% 13% or 15%. Suppose they grew by 13% per year. Then, by the year 2000, roughly 21% of the GNP would be absorbed by health care. Would this development drive the U.S. into the poor house? Not really. As is shown in the bottom row of the table, there would still be 33% more real non-health GNP per capita in 2000 than we enjoy now. We could have health care, a Perdue chicken in every pot and an entire house full of mind-boggling video games!

If our health care expenditures do constitute a crisis, they do so in one and/or the other of the following ways.

First, the presence of a third-party payment does impair the benefit-cost calculus that accompanies the purchase of ordinary commodities for which consumers foot the entire bill. The transactions leading to health care expenditures lack economic legitimacy in this technical sense. To the extent one finds this disturbing, however, one is clearly concerned over a benefit-cost crisis and not an expenditure- or cost-crisis. There is a difference between these types of crises.

The second way in which health care expenditures at any aggregate level can constitute a crisis is the manner in which we finance these expenditures. While health care expenditures may not represent a strictly macroeconomic problem, they are demonstrably a source of widespread, and often capricious,

TABLE 3

PROJECTED IMPACT OF HEALTH CARE EXPENDITURES ON NON-HEALTH GNP PER CAPITA

UNITED STATES--1980-2000

	ASSUMED AVERAGE ANNUAL GROWTH IN NOMINAL HEALTH CARE EXPENDITURES (Nominal GNP Assumed to Grow at 9%/Year)			
	9%	11%	13%	15%
A. National Health Care Expenditures in billions of nominal dollars	$1,495b	$2,231b	$3,328b	$4.965b
B. Health care expenditures as percent of GNP in the year 2000	9.4%	14.0%	20.9%	31.2%
C. Average annual growth in real non-health GNP per capita, in 1976 dollars	2.1%	1.83%	1.42%	0.72%
D. Total percentage increase (over the two decades) in real non-health GNP per capita	52.0%	44.0%	33.0%	16.0%

ASSUMPTIONS: Nominal GNP will increase at an average annual rate of 9% from its base-year value of $2,626 billion in 1980. Total health care expenditures in that year were $247.2 billion or 9.4% of the GNP. The general price level will increase at an average annual rate of 6% and the U.S. population is assumed to grow at an annual rate of 0.9%, from a base of 231.7 million in 1980. All growth rates are compounded continuously. The equivalent annual growth rates compounded once a year, would be: 9.4%, 11.6%, 13.9% and 16.2%.

budgetary crises in private households, in private business firms paying for their employees' health care, and in governments at all levels. Roughly one-third of total national health expenditures now flows through federal, state and local budgets where they are causing serious budgetary dislocations. Just as hard-pressed are some of the nation's business firms who are forced, under our peculiar system, to pay for the health care not only of their own employees, but also for the bad debt booked by hospitals for health services rendered to the nation's millions of uninsured poor.[3] Finally, in the economically depressed areas of the nation private households are now reported literally to be trading off food for health care. All of these budgetary crises are very real and often very painful.

I do not wish to belittle these crises. At the same time, as an economist, I would not know how to eliminate these crises without resort to some national health insurance scheme that provides at least catastrophic coverage for everyone, with the term "financial catastrophy" closely linked to the individual's ability-to pay. Short of such a program, the numerous incidents of fiscal agony at the local level will remain regardless of the level and growth of overall national health care expenditures.

It may, of course, be the case that Congress' interest at this time is simply to reduce the government's outlay on health care as some contribution to a balanced budget. Such a step is unlikely to be accomplished without shifting a fiscal burden either to patients, to providers or to the business sector at large. My views on such a step should be uninteresting for they would be those of a citizen and not those of a professional economist. An attempt to offer a professional view on the matter would be likely to entice me into my profession's favorite pastime: the practice of politics in the guise of science.

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[3] The mechanism is as follows: Both statutes and ethics compel American hospitals to treat the uninsured when they are seriously ill. Should hospitals fail to collect directly from these patients, they will pass on the resulting bad debt to insured patients. Remarkably, the Federal government refuses to pay for such bad-debt allocations under its Medicare/Medicaid programs. In the end, the hospitals have no choice but to shift these costs to the commercial insurers who, in turn, incorporate them in their premiums and bill them to employers.

The **Chairman**. That was a very provocative and interesting statement.

Let me start with you, Dr. Sloan. Could you please describe what our system would be like under a national health care system, because we have the two opposing points of view here today.

Mr. **Sloan**. It is rather simplified to say, well, we could have national health insurance or we could have price competition. The people who are going to have to deal with the system every day are going to have to work out a lot of details, and it is really on the details that I see the control mechanism as failing.

Certainly, we have had some experience with controls. We can talk about Germany; we can talk about the UK. But we have had experience over the last decade. The control system has not worked in our political environment. I don't think, even if I were for it, that I would see that it would have any efficacy.

The certificate-of-need programs, we spent a lot of time on those. They have not done a thing. The rate-setting programs are the only programs that have done something here. Now, the reason that——

Senator **Kennedy**. They have done what?

Mr. **Sloan**. The rate-setting programs have had some impact on hospital cost inflation, where, indeed, the cost problem has been. So one problem is that we are not able to, or as a society, we do not seem to be willing to exercise these controls, and we have to deal with the system that we have and our system of government and the preferences of our public.

The second thing is that if we were willing to exercise the controls, clearly, there would be something to give up as well as something to get. I mean, we clearly get some equity, but we are certainly not going to have the innovation; we are not going to have the amenity levels that we now have. I mean, all you have to do is to go into a Soviet hospital. I mean, they have contained health care costs. I walked up four flights of steps to reach the fourth floor because there was no elevator in a clinic in the Soviet Union.

Certainly, we as Americans expect the providers to be available at all hours. That won't happen under controls. There is no way to make somebody answer your telephone call at night. Currently, our physicians are asked to do that.

So I have no question that we would have one-tier health care. The question is, what tier?

The **Chairman**. I see.

In our country, existing public spending for health care has very little cost sharing, yet private spending does have a higher share of cost sharing.

Furthermore, public spending for health care, as I recall, has increased ten-fold between 1965 and 1978. I think those figures are accurate. Now, that is almost exactly twice the rate of private spending. Would you care to explain this?

Mr. **Sloan**. That is right. I mean, it is not like we have not devoted resources to health care. The rate of increase in the Medicare program, for example, has been something like 11 percent a year, 10 percent a year, in recent years, in real terms; that is, adjusting for the cost of living, it has gone up at this rate.

Now, I guess I would say that in a world in which we had no tax subsidies and no other interventions, maybe we could learn something by that percentage of GNP as to what the American people want. However, we have all those imperfections, and it just seems to me that 10, 11 percent, given the current budget deficits we have, that rate of increase has been quite a commitment to spending in this country, and with that 11 or 12 percent, we are devoting so much of the resource base to health care that we have all these other demands—demands for improved schools; we say our highways are breaking apart, our bridges, and so forth. Where are those resources going to come from if in fact this Medicare program continues to eat us alive?

The CHAIRMAN. I see.

Let me just ask you this. There are two theories of thought in this area. One is the two-tier health care system, that we have a two-tier health care system which liberals tend to brand as good or bad health care. The Commission on Bioethics says that we have a two-track health care system. That means that low-income individuals in our country are, although on a different track, receiving quality health care, but in different settings than others. It has been pointed out that if President Reagan needed health care, he would have to go to a public hospital if an emergency occurred, which in fact could occur.

Therefore, people say our system can provide various types of care, but we are affording, basically, quality health care in the United States. Do you differ with that analysis?

Mr. SLOAN. No. Whether you call it two-tier, two-track, or whether it is multitier, there are indeed two or more tracks in this country. There are two tracks in every other aspect of human activity in our society. The houses are not equal. The schools are not as equal as we would like them. I don't think that equality, total equality, is achievable.

The CHAIRMAN. I see.

Have increased regulations contributed to our current health care cost inflationary problems, and what would further regulations do to the current market? You see, one of the issues we are confronted with is should we have more regulation; should we have the Federal Government come in and do more; or just what is the answer?

Mr. SLOAN. I just completed an analysis of the determinants of hospital cost inflation during the 1970's, and my conclusion was that regulation, if anything, increased the rate of inflation rather than reducing it.

So, in other words, if there are regulatory tricks, we haven't found the right ones in this country. Certificate of need again contributed; section 1122 never really got going; the PSRO, according to my work, did nothing; in fact, things have increased. We can say that there are reasons that that program would have actually increased inflation.

The CHAIRMAN. In your studies, what percent would you say regulation has increased the health costs in the society?

Mr. SLOAN. I am not sure I completely believe the number, but something like 9 percent, 10 percent.

The CHAIRMAN. What would that mean in a cost per day?

Mr. **Sloan**. Well, on most per day it maybe was about 8 percent. I guess it depends on what year's dollars you take as to what that is.

The **Chairman**. I see.

Mr. **Sloan**. But a substantial increase not only in cost per day but in total systems cost.

The **Chairman**. Now, are there current Federal barriers, or State and local barriers, to encourage competitive bidding and preferred provider organizations, PPO's?

Mr. **Sloan**. There are some. There still exist some barriers that are not statutory but as quasi-statutory in that it is difficult to get privileges if you are trying to put this kind of an innovative plan together. That is why I advocated the anti-trust be maintained. I feel very strongly about that.

The **Chairman**. I understand.

Now, you state in your testimony that health planning laws should be eliminated. How, then, should capital expenditures and the allocation of resources be dealt with under a health care cost system?

Mr. **Sloan**. Capital expenditures would be part of a prospective rate and would not be set out separately. The problem with capital is the reimbursement system, and if you want to solve the capital problem, you look directly at the payment rate per diem or per case, but not at certificate of need to solve that.

If there is too much capital in this country, it has been because of the retrospective system which has passed all that stuff forward to the payer.

The **Chairman**. I see.

Dr. Reinhardt, in your testimony, you conceptually endorse a national health insurance program for the United States, or at least I interpret it that way. In the Washington Post article of November 22 and 23, they described England's program of nationalized medicine. Simply, they state that there is rationing of health care, delays and waiting lists in receiving treatment, and that people are opting out of public programs into private health insurance plans. In fact, according to that article, there is a 27-percent increase in private health insurance programs, and 4 million individuals—or 1 person in 15 in the United Kingdom—are currently using private care systems.

Now, I just ask you, is this really the kind of program that you would endorse for our country, and do you have any cost estimates on the national health insurance program that you seem to be advocating?

Mr. **Reinhardt**. No, Senator Hatch; I think I did not communicate correctly if you have the impression that I would advocate for the United States the British Health Service. Nothing could be further from my mind. There is plenty of writing I have done that would go against that.

The **Chairman**. Is there any comparable service you would advocate?

Mr. **Reinhardt**. No. In fact, in my statement I emphasize that I do not advocate national health insurance at this point because I am persuaded that under our political system it may just not be possible to implement the administrative controls a national health insurance system requires. In other words, what I am saying is, I do not believe Americans are capable in this area to do what Canadians have done, for reasons that reside in the political process used in the United States.

What I advocate in my paper is something quite different: I come out for two-tier health care. As noted, I say I take it as a given, as almost the natural state, that national health insurance in this country has absolutely no political prospect— certainly not in this decade—because of the manner in which we make health policy. If that is the case, we really at this point have a choice only among alternative two-tier (or, really, multitier) health care systems.

There is one system I call haphazard. It is the one toward which we seem to sail now. Undo this haphazard system, we perpetuate the conforting myth that we have one-tier health care, and we balance the budget simply by eclipsing some people altogether from health care. They are simply "off the rolls." Thus, we simply cut medicare and medicaid benefits, and we "clean up," so to speak, the medicaid rolls. Some people lose health insurance coverage altogether.

One read in the Medical Tribune that in the Midwest, people are trading off food for health care at this very time. That is the kind of brutal, haphazard two-tier health system our proud nation should, in my view, avoid.

The system I advocate would be more along the lines now pursued in the State of Arizona, where for publicly funded patients receive care in a price-competitive system with more limited choice of provides. That is to say, you do not offer patients in public health programs unlimited choice of hospitals or physicians. You essentially enroll publicly financed patients in price-competitive HMO's, and then you let the rest of the system truly fend for itself without any Government assistance. You will eventually discover, of course, that parts of the private sector will come begging for Government controls that would help them. An illustration of this completely predictable phenomenon is now furnished by the Health Insurance Association of America which is literally asking for State-regulated uniform hospital rates to help that industry cope with the problem of price-discrimination by the hospital sector. Sooner or later our otherwise proud private sector always comes running to the Government for succor, whenever the private market gets too hot. That is as American as apple pie. Incidentally, permit me to refer once more to the efficacy of public sector control over private markets. The regulations Dr. Sloan referred to did not work because we didn't try it. For better or for worse, we don't have the stomach in America to implement the controls we legislate. I take it that this is what Dr. Sloan meant to convey to you. I agree.

Certificate-of-need did not work because the regulators were divorced from the financers. They had no local, financial incentive to control expenditures; they were not disposing of their local funds. It is, of course, the case, now that certificate of need is off, hospital building continues apace. Right?

Mr. **Sloan**. It is not really off.

Mr. **Reinhardt**. Well, I don't think it is effectively still biting into the——

The **Chairman**. We could not hear what you said. What did you say?

Mr. **Sloan**. It is on. Certificate-of-need laws have not been repealed.

Mr. **Reinhardt**. The laws have not, but the mechanism of enforcing it surely has been weakened.

The **Chairman**. Well, if I have my way, they will be repealed. Of course, I may not get my way.

Mr. **Reinhardt**. In any event, certificate-or-need law or not, I would not expect a significant abatement in the growth of hospital costs because of it. As Dr. Sloan remarked—and I agree—we just do not have the political courage to implement such laws in this country forcefully, even if they are on the books.

The **Chairman**. It might not just be a question of political courage; it might be political astuteness, too, not to have it, because if I look at it, in fact Canada can boast that its national health care system is supported by only 8 percent of their gross national product. Now, that is compared with 10 percent in this country. But if you look closely at what is happening in Canada's system—and I just was in Canada recently and heard all kinds of complaints about their system—the facts will reveal that not everybody is very happy. Doctors are striking; patients are stacked in hospital corridors; others are turned away, not because they cannot pay but because facilities and physicians are not sufficient, and medical equipment is outdated and obsolete.

Dr. Martin Baltson, president of the Canadian Medical Association, predicts, quote, As people die on waiting lists, governments are going to catch heat. The Medical Association further cites one statistic which documents 45 patients faced with 6-month waits, all of whom are considered urgent candidates for open heart surgery. So people are dying on waiting lists, and there is a lot of thunder up there in Canada that their system is not working. Really, there is some adulation for our system up there, as bad as it may be.

Mr. **Reinhardt**. But then, Senator Hatch, may I draw the logical conclusion from these remarks?

The **Chairman**. Sure.

Mr. **Reinhardt**. If Canadians are dying because they are not spending enough on health care—they are spending only 8 percent of GNP on health care—and if, as you argue,we are doing the right thing by spending 10 percent, I come back to the question I raise so impudently at the end of my statement: What is all the fuss about? If we are doing the right thing, if Americans are not dying and are not stacking up in hospital corridors, and if our doctors are happy and do drive good cars, if that is all true, that simply does cost 10 percent of the GNP. Now if, as you say, we may actually be astute in doing this, then why do we have conference after conference lamenting that very 10 percent of GNP going to health, and why are there so many congressional hearings on the problem of health care costs?

The **Chairman**. Let me ask Dr. Sloan, what is all this argument about, Dr. Sloan? [Laughter.]

Mr. **Sloan**. It is not the 10 percent; it is the 11, the 12, the 14, the 18, the 20 percent. In other words, we are on a course in this country where the 10 percent is what it is when we look at the ticker tape today; next year it will be higher, and higher and higher, and——

The **Chairman**. Well, in past years it was higher.

Mr. **Sloan**. I have no problem with that if in fact we didn't have a substantial tax subsidy on the private side, if in fact we weren't making what I see as some errors on the public side. I mean, until recently we had retrospective reimbursement and substantial full coverage under the public programs, so if in fact this were a free market, I would have no trouble with the 10-percent share. I have trouble with 10 percent the way we have arrived at it.

The **Chairman**. I take it you don't agree with Professor Reinhardt with regard to some of the comments on national health insurance, national health care.

Mr. **Sloan**. Well, I thought we had different positions, but apparently we have closer positions. I thought I was endorsing the Arizona-type system for the public programs for private programs. By removing the tax subsidy or reducing the tax subsidy, we are letting the private market work, and this is what I was advocating.

The **Chairman**. Let me just ask one more question. I have taken enough time. I want my colleagues to have sufficient time, too.

Senator **Kennedy**. Fifteen minutes. [Laughter.]

The **Chairman**. There are some advantages of being chairman, I guess. You will be next time, I suppose. [Laughter.]

Dr. Sloan has stated, Dr. Reinhardt, that regulations have exacerbated health care costs. Do you agree with that or do you disagree?

Mr. **Reinhardt**. I am really agnostic. I am sure I could show how regulation has exacerbated our problems because I am an economist and we economist are very good at making the case against regulation. The act of regulating itself, of course, engages a lot of manpower, and to that extent it is expensive. There is no question about it.

Regulation often has the effect of distorting resource allocation. For example, in New York State it was once proposed in New York that hospitals could not have more than *x* square feet per bed in buildings. Such a regulation, you can be absolutely sure, would drive up health care costs, because in an area where land is cheap, why would one constrain square feet per bed? Regulation sometime has these perverse effects.

So, in principle, it is generally true that regulations cost us some kind of money. On the other hand, often, we do get something in return—not always, but often—and one must weigh these benefits from regulation against the cost of regulation.

The **Chairman**. Senator Kennedy.

Senator **Kennedy**. It has been enormously interesting, both Dr. Sloan and Dr. Reinhardt, and I must say, I think your analysis, Dr. Reinhardt, of the mood and the atmosphere in the country is perhaps a correct one. I think I admire your courage by your right upfront suggestion that if we are going to deal with scarce resources and the projections of additional expenditures over a period of time, we ought to talk about the two-tier system, because that is where we are headed.

I listened to, I think it was Dr. Sloan, saying, well, there are other inequities in our society, and we cannot solve all of these, so, really, you know, why bother? The fact is that in some part the United States infant mortality rates are escalating. The health care needs for the very poor in our society are not being met.

With the kinds of recommendations that have been made by Mr. Feldstein this morning in his statement about requiring elderly people—those who are in greater need of health care to pay more out of their pockets, with scarce resources, it is going to keep them away from the doctor, keep them away from primary care and other kinds of preventive care. Their health is going to deteriorate.

The experiments which have been done with prepaid programs that show that people have have access to doctors in the early period of their illness and sickness are saved from spending longer periods of time in hospitals

I would just point out—and in the time that we do have available, I don't want to get into the involvement of the debate on national health care—but the interesting point remains that in every one of these Western democracies with national health insurance. I don't know of any political leaders or political parties that would want to repeal their national health system. And with all of these statements and studies that are read on into the record about the deterioration of health facilities and people dying in corridors and failure of access to care, I have yet to hear that Canadian parliamentarian, that Canadian political leader—they have had five national elections since they have had health service up there—or political party who has been willing to say that they are for the repeal of their health care system. I don't know of one which has been put in place which has been repealed.

Usually, politicians are pretty responsive, as we have seen around this place, to the exigencies and the whims of and the outrage of the people about different social programs. You see it on busing; you see it on prayer. The number of times that Members of Congress fall over themselves to offer various amendments to take advantage of a whim and a passion and an emotion is virtually unlimited in this body. And so we see that everywhere.

What we are talking about now is the trends in increased costs. What is being recommended to us is to reduce benefits. No one denies that you can reduce the cost of the health care system when you reduce the benefits. We have had the guts to add the benefits over a long period of time; now we are paying the piper.

The real question is how we are going to pay the piper. I think in your statement here, your chart here is a remarkably brilliant chart which I think probably spells it out very, very clearly. I mean, we hear hour after hour of testimony, but I think your chart says that you have those competing choices—whether you are going to have equity or whether you are going to deal with cost, and then whether you are going to restrict some kind of freedom in terms of how the health professions are going to be practiced in this country. I think you have identified those factors very clearly.

Clearly, we are going to deal with it. We are going to have to choose among those various factors.

I just find it inconceivable that we can leave it to the market. We have in my own State of Massachusetts 3,000 excess hospital beds. We have over 800 hospital beds now that are in the planning process, just waiting to be built. Unless you have someone—in this case it is a State agency—which is able to review that, we know what is going to happen and who will end up paying for those hospital beds. It is going to be medicare; it is going to be the Feds, by and large. It will be some expenditures out of individual pockets if the administration has its way in terms of hospital copayments, as that chart indicates. They are going to end up paying. But it is also going to be Federal expenditures. The idea that we are going to be spending more falls right back on the fact that we are permitting these massive capital committments and refusing to have any kind of say about how those are going to be allocated.

I am just interested in a number of the charts that you have here, but one which I thought was interesting is figure 6.

The administration is talking about more out-of-pocket payments. On chart 6, you show here, as I understand it, that the United States is right up there at the top in terms of percent of GNP spent on health care and in out-of-pocket expenditures.

Now, what does that say to you? How effective has this been? What is this going to mean if we just keep increasing out-of-pocket expenditures? Your chart says we are spending more and we still have more out-of-pocket expenditures.

What we are hearing now drummed into the Congress and Senate is that the answer is more out-of-pocket expenditures. On the one hand, we see the deterioration in terms of the quality of health for people in our society through growing financial barriers, and on the other hand, you show that it hasn't been very effective in terms of doing a darn thing about cost.

Mr. REINHARDT. Well, certainly the data are there for you to see, I consider table 1 and figure 5 of my statement a gift to my dear friend Frank Sloan. I know that from childhood days on, Dr. Sloan has wanted price-competitive health care markets. Coming down here this morning I asked myself what I could do for my friend and colleague, and then I thought of table 1 and figure 5. These displays show that half the sector is a already a price-market.

There is no insurance for dental care unless you work for the Rand Corp.—they probably have it—there is no insurance for drugs. There is no insurance for eyeglasses, for medical supplies. Only 50 cents of every health care dollar really has health insurance with substantial first-dollar coverage, and that is the hospital sector. If you want to do something about the hospital sector, you could certainly introduce a 30 percent cost sharing up to, say, $3,000 a year, as has been proposed.

The problem with that is two fold, of course. The incidence of that will be brutal on some low-income households. $3,000 for a household making $10,000 is a lot of money. That is really a lot of money.

Second, in any given year, 75 percent of all health care expenditures accrue to only 10 percent of the people. That number needs to be repeated. Seventy-five percent of all health care outlays are absorbed by 10 percent of the people. I take it that these people are truly very sick, and that is why they are absorbing the bulk of these expenditures. The problem is this: Even with significant cost sharing, very sick people will quickly have exhausted their maximum out-of-pocket limits, whereafter they receive first-dollar coverage. Once they are at the 15th day in the hospital, cost sharing will not do anything because the Rand Corp. study has clearly shown that once a person has gone to the hospital, the cost sharing has very little impact on the utilization thereafter. It is admissions that go down as a function of cost sharing, and doctors' visits.

The two-tier system that I was talking about is not the brutal one you talk about, Senator Kennedy, where we would eliminate benefits and eligibility. Rather, we should think of it as a publicly administered PPO—preferred provider organization. We would offer the aged and the poor completely comprehensive benefits. The only thing they could not do is to go for every episode to 15 doctors in a row. They would have to go to a panel of doctors who have agreed to accept medicare assignment. They would have to go to a set of hospitals who have agreed to negotiate with medicare a prospective reimbursement rate that may, for all we care, be different from the rate they charge Prudential's clients. Only by limiting provider choice will the public sector ever gain the market power to deal with a hospital in, say, in New York, and state: "Look, we will pay you $400 a day, no more, no less. If you want to take our business, fine. If you don't want it someone else will." That is what I have in mind with the two-tier health system I advocate. It would be humane; we could make some of that.

Senator KENNEDY. I thank you. We have a quorum here. So I appreciate your response.

Senator PELL. I have one short question, if I could.

In your very interesting graph, what portion of the percentage of devoted GNP is from the private sector and the public sector?

Mr. REINHARDT. If you will refer to the next figure, figure 3, it has at the bottom, page 1-c, those data.

Senator PELL. I see it.

Mr. REINHARDT. Right. There it is.

The CHAIRMAN. Are there any other Senators who would like to ask a question or two of these two? You didn't have a chance to respond, Mr. Sloan.

Let me just say this. We have eight Senators here. We need two more to be able to complete this markup. Would staff please ask their Senators to come? Hopefully, at the end of this panel, we can mark up these three bills.

Dr. Sloan?

Mr. SLOAN. I don't have a graphing device here, so I cannot draw another graph.

The CHAIRMAN. We would be happy to keep the record open if you would care to supply one.

Mr. SLOAN. Thank you. But we could imagine another graph that would show the year 1966, when the medicare and medicaid programs were implemented, where there was substantial decrease in cost sharing, and at the same time there was a substantial increase in the percentage of GNP devoted to health care.

Now, I am not sure what that chart would show any more than this chart shows. The problem is that we have not looked at the other factors that determine health care expenditures. Cost sharing is only one. Nobody would maintain this is the only factor.

This is one of the wealthiest countries in the world. We know that higher income leads to higher health expenditures. You would have to look at the demographics. You would have to look at the physician supply situation. You would have to look at the bed availability. There are a whole lot of factors that go into these proportions that are reported in the chart.

And so I am not sure that we learn much by looking at a two-dimensional diagram. I guess I am one of these economists who might show that cost sharing leads to lower expenditures on health care for a fee. I will even do it for no fee.

Now, the other thing about the Rand Corp. study, Rand did report what Professor Reinhardt said. Now, the problem is that the dollar ceiling on expenditures was fairly low in that study. If another ceiling had been tried, different results would have been obtained. I do not think those results are conclusive except on admissions. I don't think they tell you much about how much is spent on the hospital once the patient is in the hospital.

I would also say that I would much rather see a graph that dealt just with the hospital, because here we have mixed a lot of apples and oranges. Long-term care is very poorly covered. Hospital care is very well covered. Physicians' services are somewhere in between. What we should be doing is looking at that part of the health system here which is very well covered, which is hospital care, and then compare that to what is happening in the other countries.

The CHAIRMAN. Thank you, gentlemen. We appreciate your testimony and appreciate having you here today.

Mr. REINHARDT. Thank you.

Mr. SLOAN. Thank you.

The CHAIRMAN. With that, we will recess this hearing for a few minutes and see if we can get one more Senator so that we can have 10 Senators here in order to mark up the three bills that we would like to move out.

[Whereupon, at 10:43 a.m., the committee recessed, to reconvene in a markup session, after which the hearing was resumed at 11:52 a.m.]

The CHAIRMAN. The committee will be in order.

Our third panel represents two differing methods which States have implemented for controlling health care costs.

It is important that States retain the flexibility in reducing health care costs according to individual State needs. Federal direction should not mandate State activities, in my opinion.

Today's panel highlights two separate approaches States have implemented for combatting health care inflation.

Our first witness is from my home State of Utah, which has successfully maintained lower health care costs through competitive nonregulatory approaches.

Our second witness is from Massachusetts, a State which has developed a ratesetting utility approach to containing health costs.

I am pleased to welcome our own Dr. Nelson to Washington. Dr. Nelson is the president of the Salt Lake County Medical Society and is a member of Utah's Health Care Cost Containment Management Foundation Committee on Plan, Decision, and Benefit Administration.

Our second speaker is Mr. Manuel Carballo, who is the secretary of the executive office of human services in Boston, Mass.

We are delighted to have both of you here. I have to apologize, Dr. Nelson, because I have another conflict. I have to run. I am quite late because of the markups. Senator Hawkins, who is my right-hand person on this committee in health matters, has agreed to chair the remainder of these hearings, and I really appreciate having both of you gentlemen here today.

I apologize to you, Mr. Carballo, as well for not being here to hear your testimony, but I will read it, and of course we are extremely interested in this area. So thank you, and thank you both for being here.

Senator Hawkins?

Senator HAWKINS [as Chair]. Thank you.

Dr. Nelson, will you begin, please?

STATEMENT OF JOHN C. NELSON, M.D., PRESIDENT, SALT LAKE COUNTY MEDICAL SOCIETY, AND MEMBER, UTAH HEALTH CARE COST CONTAINMENT MANAGEMENT FOUNDATION COMMITTEE ON PLAN, DECISION, AND BENEFIT ADMINISTRATION, SALT LAKE CITY

Dr. NELSON. Thank you very much.

Providing quality health care to patients has become a very complex situation because of critical cost problems. In order to understand these problems, the interactions among all groups involved in the delivery of health care services must be understood.

Primary groups include physicians, hospitals, third-party payers, government, and patients. Industry, who pays a large amount for employee health insurance premiums, and the legal profession, particularly with regard to professional liability, may also be included.

At this point, however, every portion of the health care delivery system has an incentive to consume. Physicians are paid by the case. Hospitals are paid for full hospital beds. Third parties increase premiums, which may increase profits, in order to add more services.

The government regulatory process, such as certificate of need, has been time-consuming and expensive. Finally, the patient, usually covered by a third party, uses his benefits because they are all paid for.

The situation is critical and needs addressing. We suggest three alternatives for consideration: maintaining the status quo, initiating regulation, or developing private sector initiatives. Let us briefly examine each of these possibilities.

The status quo is not acceptable to most of our society. Patients will not be able to pay higher costs for care. Insurance companies cannot continue to provide coverage, and business and industry can no longer afford to support the health cost burden.

Regulation, the second alternative, has the potential of establishing maximum rates of utilization and/or reimbursement. But in many instances the regulatory process has been slow, inflexible, and expensive. Further, the key factor to successful delivery of medical care—and I must emphasize this—the doctor-patient relationship, is replaced by the practice of medicine by committee.

We favor the third alternative, developing the private sector. The private sector in this country has responded again and again when challenged to do so. We must rely on American ingenuity and know-how to deliver us from the health care cost dilemma.

It is important to realize that the groups involved in the health care system will have to work together to accomplish this essential task, and we believe physicians can provide the leadership to make this happen. As physicians, we have been trained to care for our patients, but a natural corollary is that we also care about our patients. We are aware of the cost problem. We have the technical ability to assess our patients' needs. We can evaluate cost and quality considerations and tradeoffs we must make. We have a unique opportunity to teach our patients, and, most importantly, we are motivated.

Our Salt Lake County Medical Society, at the grassroots level of medicine, is soliciting input from each of our 1,400 members. In small groups, in an organized manner, we are allowing each physician to list his own personal agenda for solving the health care problem. The details of this undertaking are in the printed testimony which you have already received.

We are learning some interesting things. First, physicians in Utah are identifying virtually the same agenda. Second, many areas have been listed in which physicians may make an impact on costs. Third, and significantly, there are also many areas where our ability to effect change is very limited. The data gathered from this experience will form the basis for a prospective plan to be approved and implemented later this year by the physicians.

While the plan is yet to be formulated, we can now see some of the elements of the plan. First, we will rely heavily on patient and physician education. The skill gained by our peer review organization, the best in the country, one that works, in evaluating quality care considerations for medicare, will be utilized to identify ways in which physicians can practice more cost effectively but without decreasing the quality of care.

Lengths of stay by diagnosis, procedures which may be done on an outpatient basis, laboratory tests and treatment methods can all be analyzed for cost effectiveness, and many have been already. These analyses can be used as a basis for extensive physician education and cost containment on a patient-by-patient basis.

The patient, too, can be educated through physician efforts to utilize the system more efficiently. This is now being done one on one by physicians in their offices and on a broader scale through seminars, pamphlets, and the public media.

Second, the medical society will initiate discussions with other segments of the health care industry to help them find solutions through physician experience. Much of this will be accomplished through active participation in the Utah Health Cost Management Foundation. The Foundation is a coalition of business, industry, insurance, government, and provider representatives, voluntarily formed to search for solutions to the health care problem.

The program of the foundation includes improvements in health insurance plan design, competition among alternative delivery systems, consumer information on costs and prices, and improvements in insurance benefit administration. All of these efforts are designed to increase the incentives for cost effectiveness and to eliminate the blank-check attitude which now pervades our reimbursement system.

Finally, and this is important, the low utilization rates and shorter lengths of stay in Utah are no accident. Low-style medical practice is the norm for our physicians. A healthy lifestyle is a major contributing factor. It is estimated that $125 billion was expended in 1980 for diseases relating to alcohol and tobacco and to accidents. All of these costs were preventable.

The health care industry must teach its consumers—our patients—the value and cost savings they can make by living healthy lifestyles.

The physicians of the Salt Lake County Medical Society enjoy a good relationship with Governor Matheson, the Utah State Legislature, the Utah State Department of Health, the media, and the other important members of the health care delivery team. We believe that with appropriate leadership' we can, and we will, work together to curtail health care costs while maintaining quality of care.

Our goal is clear, our agenda is full, and the time is short. I hope to be able to return to you with a full report of our success in the near future.

Thank you.

[The prepared statement of Dr. Nelson follows:]

PREPARED STATEMENT OF JOHN C. NELSON, M.D.

PRIVATE SECTOR INITIATIVES IN HEALTH COST CONTAINMENT IN UTAH 1983

INTRODUCTION

Health care in the U.S. in 1981 consumed $288 billion or 9.8% of the gross national product. Health care expenditures have doubled every seven years since 1955 and are still rising faster than the Consumer Price Index for all goods and services. Utah's health costs have followed the same trend experienced in the rest of the nation but are generally 20-30% below national levels by many measures.

To understand the complexity of the problem of runaway health costs, it is necessary to understand the multi-faceted nature of health care. There are at least five major groups involved in the health care system: (1) physicians, (2) patients, (3) third-party carriers, (4) hospitals and (5) government. Other groups such as industry and the legal profession may also be justifiably included. Each group makes its own unique contribution to the rising costs of health care and has its own particular agenda for curtailing the spiraling costs. Too often there has been no amalgamation of forces or unity of purpose among the groups in the health care system to solve the cost problem and, in many cases, it has been an exercise in "blaming the other party".

The Salt Lake County Medical Society identifies three alternatives for resolving the cost problem: (1) maintain the status quo, (2) increase government regulation, or (3) increase private sector initiatives.

POSITION TAKEN BY SALT LAKE PHYSICIANS

Salt Lake County physicians reject the status quo. Patients will not be able to pay increased costs for care. Insurance companies cannot continue to provide coverage and business and industry cannot continue to support the health cost burden.

Salt Lake County physicians also find the regulatory option unacceptable. It is unwieldy, expensive to administer and leads to inappropriate decisions made on a group basis rather than on an individual patient-by-patient basis.

Most physicians in Salt Lake County feel private sector initiatives represent the best alternative for resolving the cost problem. It uses the combined expertise of all of the major groups in the health care system to address economies in their own areas and to work cooperatively with other groups to accomplish economies throughout the system.

Physicians can play a major role in private initiatives. Their effective leadership has lead to the development of the most effective, high quality health care system in the world. This same leadership is ready to develop a cost effective system.

COST PROBLEMS ADDRESSED

In Utah, physicians have approached the cost problem in three ways: first, by educating physicians about cost problems and assisting them to practice cost effective medicine; second, by educating the consumer on cost effective use of the health care system; and third, by cooperating with and providing leadership for private sector initiatives that bring together representatives of the groups within the system in joint problem-solving activities.

Enhancing Physician Cost Effectiveness

1. Cost Containment Seminars

The Utah State Medical Association and its component society, the Salt Lake County Medical Society, feel strongly that an effective non-regulatory cost containment program must involve every practicing physician in the state. While physicians are trained to practice quality medicine, they have received little training in cost effectiveness. To encourage education and problem solving the Medical Society organized an effort to involve every physician in a series of cost containment "roundtable" workshops.

Each of the 1,400 physicians in the Salt Lake County Society will be encouraged to take part in a roundtable discussion containing eight to ten fellow physicians. Each roundtable has a group leader who is trained by the County Society Executive Committee in procedures and techniques for defining problems and solutions. Physicians are asked to determine an appropriate goal for curtailing health care costs. After the goal has been decided, each physician is asked to list on a card five factors which have lead to the increase in health care costs. The group leader asks each physician in turn to name a factor and then lists it on a board. The process is repeated until every physician has listed all identified problems. In a group of ten physicians it is not unusual to receive 40 to 50 different items which the physicians feel lead to health care cost increases.

Once the group has listed the factors contributing to health cost increases, the group leader asks the physicians to suggest solutions to the listed problems. Again the solutions are written on cards by each physician and the group leader asks each physician in turn to list one of the solutions until all are recorded. The leader of each of the cost containment roundtables records the data gathered in the session and forwards it to the County Medical Society offices to be collated with data received from all other groups in the state and county societies.

The data from the roundtables will be assembled and analyzed by six cost containment task forces who will develop one part of a Utah State Medical Association Cost Containment Plan. When finally approved by the Association's House of Delegates, the Plan will form the basis of cost containment policy for organized medicine in Utah, an action plan for improving the cost effectiveness of medical practice in Utah, and serve as an agenda for physician interaction with other principals in the health care system.

The goals of this program are (1) to increase the physician's personal awareness of the cost problem, (2) to rank and prioritize major areas where physicians have impact, (3) to help the physician understand that there are many inter-relationships in the cost problem where physicians must be involved, (4) to rank and prioritize the major areas where physicians have impact, and (5) to find all possible areas where physicians may attack the cost problem.

2. Peer Review

The physicians in Utah have lead the nation in peer review. The Utah Professional Review Organization (UPRO) was organized long before the Congress incorporated the PSRO program into Medicare. UPRO was organized because Utah physicians felt that quality medical care required effective professional review, not in a punitive sense, but as an educational tool. The physicians of Utah recognize that UPRO can be used to examine the practice patterns of physicians to determine the most cost effective ways to practice medicine without diminishing quality. With a decrease in funding for PSRO's from the federal government, Utah physicians are engaged in private fund raising to maintain UPRO and use the expertise of the organization in cost containment.

3. Economic Code of Ethics

Medicine has a strong and valued code of ethics. The leadership of organized medicine in Utah believe physicians must write and adopt a similar economic code of ethics which deals exclusively with the financial aspects of medicine. The Salt Lake County Medical Society is actively participating with the Utah State Medical Association in developing such an economic code of ethics designed to help physicians deal fairly and economically with patients and third-party payors and to better allocate health care resources.

4. Results

While many of the efforts to educate physicians and enhance their cost effective practices are in early stages, some concrete changes have been made as the result of Salt Lake County physicians' efforts. For example, a major Salt Lake City hospital has implemented a new policy that calls for all patients to be admitted for elective surgery the same day as the procedure (where medically appropriate). In the past, procedures such as elective cholecystectomies (removal of the gall bladder) have required the patient to be admitted to the hospital the day prior to the surgery. In cases where the patient is relatively healthy, the prior day admission is not medically necessary and is not cost effective. Under the same day admission policy, the history and physical exam are performed by the physician and appropriate laboratory data are gathered on an outpatient basis.

Patient Education

1. Seminars

Utah physicians have been major co-sponsors of successful seminars in the last year designed to educate patients. "Prescription for Runaway Health Costs" is a recent example of a full-day meeting co-sponsored with the Salt Lake County Chamber of Commerce and held in November 1982 at a major Salt Lake City hotel. Participants included individuals from business and industry who purchased health care for their employees, third-party carriers, governmental health officials and physicians. Over 100 participants engaged in an active interchange of ideas and discussion about ways to address health cost problems and methods for better utilization of the health care system.

2. Televised and Printed Information

The Utah State Medical Association works directly with one of three major commercial television stations in Salt Lake City to present a weekly health segment on the evening news and regular public service announcements on health topics. The medical reporter is Robert G. Wilson, M.D., President of the State Medical Association. The segment is designed to provide accurate and practical medical information including ways to reduce health expenses. The information is well received.

The Utah State Medical Association also sponsored a public television program entitled, "What Price Health Care?" The program looked at the factors which have contributed to the rising costs of health care. Factors discussed included patient lack of awareness of insurance options, procedures performed in hospitals which could be done in doctors' offices, the ordering of unnecessary tests, duplication of hospital services, and alternative delivery systems. The program was aired twice and broadcast to an audience throughout the mountain states.

The Utah State Medical Association also worked directly with KSL-TV, the largest local commercial station in the area, to present a 12-part series on the 10:00 p.m. news. The series looked at all facets of the cost problem and was designed to inform the public about cost issues and possible solutions to the problems.

Leadership from the Utah State Medical Association and Salt Lake County Medical Society met with the managing editors and medical writers for our two local daily newspapers. Issues and problems dealing with health costs were fully discussed. As a result, the reporters are responsive and give wide coverage to cost problems.

The Utah State Medical Association has provided a series of cost containment pamphlets for physicians to purchase and make available to their patients. The pamphlets describe how patients can cut their health care costs. Subjects such as emergency room use, consultations, special tests and x-rays, inquiries about prices, inquiries about drug costs and understanding insurance options are reviewed in easy to understand language. Patients are invited to discuss costs with their physicians and instructed on ways to enhance patient-physician communication.

3. Lifestyle and disease prevention

According to AMA President Dr. Dan Cloud, nearly one-half of the $247 billion dollars spent on health care in 1980 represents the costs of preventable diseases from smoking, alcohol abuse, and accidents.

Utah physicians are active in promoting healthy lifestyles in the general population. In February of this year, the Utah State Medical Association co-sponsored a seminar entitled, "Fitness at the Worksite". Nationally recognized figures were brought in to teach conference participants ways of maintaining good health and promoting healthy lifestyles at their places of employment. The seminar was enthusiastically received and upon request of the Governor's office, a similar conference is being planned for next year.

In addition to the lifestyle conference, Utah physicians have sponsored stop-smoking clinics, early detection of disease, weight loss programs and health screening fairs. Utah physicians are involved in public education geared to teach the benefits and cost savings that can result from healthy lifestyles and the prevention of disease.

Encouragement of Private Sector Initiative

1. Physician Business Interaction

The Salt Lake County Medical Society has been an active participant in dialogues with the various groups in the health industry. Utah physicians are committed to sharing cost containment ideas with the other principal groups of the health care industry. A particular initiative undertaken by the Salt Lake County Medical Society is the corporate visitation program. Leadership of the Society visit with the executive officers of all the major employers in the county to discuss their health cost concerns. The visits have been very successful in communicating the cost concerns of physicians to employers. It has also been helpful to the physicians to learn the specific problems of business. In many cases, leaders of business have requested special assistance with problems particular to their operation. Business leaders have been receptive to these visits and are beginning to take advantage of the expertise offered by physicians to solve health cost problems.

The Salt Lake County Medical Society has undertaken many other initiatives to broaden cooperation between insurance, industry, business, labor, hospitals and physicians. A major thrust of this effort has been to participate actively in the Health Cost Management Foundation. The President of the Salt Lake County Medical Society and Robert G. Wilson, M.D., President of the Utah State Medical Association serve on the Board of the Foundation. The Foundation has provided the major forum in Utah to encourage private initiative in the health cost endeavor. While physicians do not agree with all of the programs and recommendations of the Foundation, we feel a need to be actively involved in its discussions and are supportive of the concept of private initiative upon which it is based.

THE UTAH HEALTH COST MANAGEMENT FOUNDATION A PRIVATE SECTOR INITIATIVE

Addendum

History of the Utah Health Cost Management Foundation

In 1978, in response to the federal mandate requiring states to enact Certificate of Need laws, the Utah Legislature commissioned a study of Utah's health system. Its purpose was to determine if there was a cost problem in Utah and also whether there were any non-regulatory alternatives to controlling health costs. The study concluded there was a cost problem in Utah and that Certificate of Need was probably needed at least temporarily, but that there were non-regulatory alternatives to help solve the problem - competition and market forces.

The study recommended that a nonprofit, private coalition be formed to act as a catalyst for these strategies. The Utah Health Cost Management Foundation was thus established in May, 1980. It is governed by a coalition of major employers and employee groups with representation from government, insurance, and providers. It is funded by a three-year grant from the John A. Hartford Foundation (New York City), which has since been extended to four years. The Foundation is currently seeking funds from local businesses and third party payers to continue its existence.

What Are the Causes of the Problem?

There are many recognized causes of the health cost problem, including government regulation, inflation, technology, defensive medicine due to malpractice suits, and unhealthy lifestyles.

However, the Foundation believes the fundamental underlying cause is a lack of financial incentives in the system, commonly referred to as market failure. The system lacks the balancing influence of consideration of costs and prices by both consumers and providers. It also provides no rewards to providers for low costs and efficiencies and no rewards to consumers for choosing efficient providers.

These are the key elements missing in the health care industry and which are present in other sectors of our economy. This situation is due primarily to the overall predominance of third party reimbursement, and the highly valued and complex nature of medical care.

Look at the economic incentives facing consumers, physicians, and hospitals. They are all cost increasing, just the opposite of the economic incentives in the rest of our economy.

Consumers are encouraged to seek more and more care. They are largely insulated from the direct costs of care by insurance and often have no incentive to consider costs in decisions to seek care, to compare prices when choosing a provider, or to compare costs when choosing a setting or mode of treatment. Our tax laws unfortunately encourage the purchase of more and more insurance. Also, because of the complex nature of medical care, the patient is dependent upon the physician for over 70 percent of the decisions.

Physicians are rewarded financially for providing more and more care. Most physicians are paid on a fee-for-service basis where more service means more revenue. Physicians actually are penalized with a loss of revenue if they are efficient. If they avoid questionable hospitalizations, procedures, tests, or therapies, they lose revenue. Also, if they lower their prices, that does not attract new business to them, and they again just lose revenue. They do not gain by using the most cost effective hospital or setting on behalf of their patients. Without any financial incentive, it is hardly worth much of their time and effort to fight to lower their hospital's prices or to change inefficient hospital practices. Their individual efficiency is irrelevant to consumers.

Other non-financial factors also encourage the provision of more and more care by physicians. Their ethical standards require that the physician's first concern be the patient and encourage the physician to do everything possible. Professional challenge and reputation encourage physicians to do the highly technological things. And last, malpractice encourages defensive medicine.

Hospitals are also rewarded financially for providing more and more care. They are paid on the basis of costs or charges, whatever they are, and are generally assured of receiving adequate revenue to cover all expenses, regardless of their relative efficiency or price. More service means more revenue to the hospital. Hospitals are also penalized with a loss of revenue if they are efficient. If they shorten lengths of stay, reduce lab tests, treat people as outpatients, and avoid duplicative capacity, they lose revenue. Also, if they lower their prices, that does not attract new business, and they again just lose revenue. An individual hospital's efficiency is irrelevant to consumers. Hospitals compete for physicians, not patients. Such competition increases costs, primarily through the purchase and duplication of expensive equipment and facilities.

In summary, the health care system has financial incentives that (a) encourage consumers to seek more care without regard to price and does not reward them for cost conscious choices, (b) reward providers for the provision of more and more care without regard to price, and does not reward them for efficiency; and (c) make efficiency irrelevant to providers or consumers. The Foundation believes it is imperative to change these financial incentives if we are going to manage health care costs without significant government intrusion. It is also clear that the incentives of both providers and consumers must be changed.

What Are the Fundamental Choices?

There are four choices:

- The Status Quo - do nothing;

- The Voluntary Approach - self-regulation by providers;

- The Regulatory Approach - control supply, prices, and utilization; or
- The Market Approach - stimulate price competition.

The status quo is obviously not an alternative any longer. The battle between change and no change has been lost.

The voluntary approach is also not a credible long-term approach. It may help save some costs in the short run, but it has never worked well in any industry to contain costs over any sustained period of time. Its track record in the health industry over the last five years is quite poor, and it does nothing to change financial incentives.

It is a choice between regulation and the market. The Foundation has rejected regulation for several reasons. Its track record in controlling cost and promoting efficiency in any industry is not good. Regulation also does nothing to change the financial incentives of providers and consumers, except increase incentives to get around the regulations. To have any chance of successfully controlling costs, it probably has to go well beyond public utility type controls and turn the health care industry into a totally public enterprise. However, such massive controls have all the problems of centrally planned industries, including inefficient distribution, unresponsiveness, lack of innovation, rigidity, and undercapitalization. For these reasons, the Foundation has chosen to pursue the market approach.

What Are the Solutions?

The essence of competition is to instill price sensitivity among both providers and consumers, and to give them economic rewards for being cost conscious. To have price sensitivity, there must be a working price mechanism. There are two possibilities: individual service prices and insurance premiums. The Foundation is pursuing strategies based on both of these price mechanisms, as well as some short-term strategies that do not directly involve either price mechanism. Some strategies have more long-range potential than others. All of them have certain limitations which must be recognized.

1. Improvements in Plan Design

The first strategy involves increasing the amount of cost sharing in health benefit plans. This strategy focuses almost exclusively on making the consumer more sensitive to costs. It uses the individual service price as the price mechanism, so that providers compete over service prices, as well as over quality, service, and access.

There are two general approaches to cost sharing being promoted by the Foundation. The first involves general cost sharing such as deductibles, copayments, and fee schedules, all of which require the consumer to pay a portion of the costs at the time of service. The second involves utilization - specific cost sharing. This approach provides broader coverage or actual bonuses for certain desired utilization patterns. For example, provide 100% coverage for surgeries done as an outpatient, but only provide 80% coverage for surgeries done as an inpatient. Or charge a $50 deductible per day for each hospital day longer than the average stay and give a $50 cash bonus per day for each day less than the average stay.

General cost sharing has been proven moderately effective in reducing utilization. Moderate copayments (i.e., 20%) will reduce utilization by 10-20%. No studies are yet available on utilization - specific cost sharing, although the Foundation is currently evaluating one such experiment.

Cost sharing does, however, have some definite limitations. First, it is still unknown whether or not cost sharing encourages consumers to avoid getting care they really need. Second, physicians still control most of the utilization decisions, due to the complexity of the medical care product, and cost sharing does not affect providers' financial incentives. In response to cost sharing, providers may simply raise their prices, unbundle their services, or order more services.

Third, except for items with low unit costs, cost sharing does not promote comparative price shopping, or in other words, encourage consumers to use low cost providers. Most hospital costs exceed the deductibles or stop-loss provisions of insurance policies. Price differentials are too small with 20% cost sharing (e.g., the consumer's share of a $100 price difference is only $20). Also, meaningful price comparisons and other types of consumer information are usually not available.

Fourth, and perhaps most important, is the fact that consumer resistance to cost sharing is high. Americans are quite risk adverse and are willing to buy extra coverage.

Despite these limitations, however, the Foundation believes cost sharing should be pursued. It may moderate marginal utilization, at least in the short run.

Foundation activities to improve plan design have included the following:

- Educating major employers on the benefits and limitations of cost sharing.
- Evaluating the benefit packages of major employers and recommending changes to achieve more effective cost sharing.
- Providing technical assistance to insurers in more effective plan design.
- Evaluating the impact of a cash bonus program for outpatient surgery and shortened lengths of stay.
- Resisting attempts by special interest groups (mostly providers) to pass anti-competitive legislation in the Utah Legislature.

2. Competition Among Alternative Delivery Systems

The second strategy involves encouraging the development and offering of competitive Alternative Delivery Systems. It focuses on making both the consumer and provider more sensitive to cost. For this reason, the Foundation believes it has more long-range potential than cost sharing and other short-term strategies.

It uses the premium as the price mechanism so that providers compete over a price that represents the aggregate of most all services. Consumers can make wiser and more rational choices among several competing premiums than they can among thousands of individual service prices, as in cost sharing.

To create competition based on premiums, a substantial number of providers must be organized into reasonably discrete sets that then compete with each other and with traditional providers and insurers. These sets of providers, termed Alternative Delivery Systems, all have several things in common. First, a subset of providers in the community agrees to provide services to the plan's enrollees. Second, consumers who voluntarily enroll in the plan agree to get their care from those providers (to obtain full coverage). Third, the consumer pays a premium that reflects the relative costs and efficiency of the participating providers.

There are many types of Alternative Delivery Systems, including preferred provider plans, HMOs of all types, health care alliances, and direct contracting arrangements. They can be sponsored or organized by providers, third party payers, employers, or some combination of the above.

For competing Alternative Delivery Systems to have a beneficial effect, two things need to happen. First, there must be a number of strong diverse plans. The market must have more than one or two competitors. Highly respected providers must participate in the plans, and monopoly plans and plans with an overlap of providers must be avoided.

Second, consumers must have an opportunity to make a fair choice among competing plans. This means that employers must offer their employees a free choice among several Alternative Delivery Systems, as well as the indemnity plan. Also, employers must make an equal dollar contribution toward the premium of the plan of the employee's choice, with the employee paying or being rebated the difference. Such choice is critical to this strategy's success. Otherwise, providers are not competing for consumers on the basis of price.

The effect on both provider and consumer incentives can be significant. A plan that includes physicians who practice cost effectively (e.g., fewer admissions, shorter stays, less use of surgery, testing and drugs) and hospitals with lower prices and efficient operations will either have a lower premium or broader coverage. If the employer contribution is equal for each plan, then employees choosing the more efficient plan are rewarded by paying less toward the premium, or by getting more benefits. For the first time, a mechanism also exists to reward efficient providers and penalize inefficient providers. Providers in efficient plans will attract new patients. Providers in inefficient plans will lose patients to more efficient plans.

There are many studies on the effectiveness of HMOs, but none on other types of Alternative Delivery Systems. Individual HMOs (even without competition from other HMOs) have generally reduced hospitalization by 30-50%, after adjusting for population differences. Total costs per person in a HMO (including out-of-pocket) have been shown to be 10-40% lower than the fee-for-service sector. In mature HMO markets, the HMO premiums have usually crossed underneath the traditional indemnity premiums after several years.

The approach of competitive Alternative Delivery Systems also has some limitations that must be recognized. Development of strong plans is difficult. Most providers do not feel the need to compete on price if they do not have to and actively resist any change in the status quo. Purchasers are also reluctant to go out and encourage providers to form or participate in Alternative Delivery Systems. Negotiating direct contracts with providers is new for most employers and third party payers, although it is something that employers do all the time for other services they buy.

Obstacles also exist to offering employees a multiple choice. This requires some minor additional expenses and some administrative changes. Also, if not properly managed, the offering of several plans may create some temporary adverse selection problems.

Foundation activities to encourage the development and offering of Alternative Delivery Systems have included the following:

- Providing encouragement and technical assistance to providers in developing Alternative Delivery Systems.

- Providing encouragement and technical assistance to insurers in developing Alternative Delivery Systems.

- Improving the legal environment for development of Alternative Delivery Systems by working to revise an antidiscrimination law (prohibiting Preferred Provider Organizations) and revising the state HMO law.

- Explaining the benefits of competition among Alternative Delivery Systems to employers, encouraging them to offer multiple choice, and providing them technical assistance on how to do it.

- Assuring the antitrust laws are enforced.

- Educating physician leadership on the merits of competition among Alternative Delivery Systems.

3. Provision of Information to Purchasers and Consumers

A third strategy of the Foundation is to give purchasers and consumers some help in making more informed decisions. Besides having an incentive to consider costs and choose efficient providers, purchasers must have information to do so. If information is inadequate, they will not make wise choices and the competitive market is dead.

Foundation activities to provide information to purchasers and consumers have included the following:

- Developing and publishing a series of 10 consumer information pamphlets that provide comparative prices, by hospital, for 20 surgical procedures, and ideas on how to better use the system (i.e., staying healthy, how to choose a doctor and a hospital, the office visit, surgical care, dental care, drug use, maternity care, and understanding health insurance).
- Initiating development of a data project for third party payers to help them identify cost-effective providers.

4. Improvements in Benefit Administration

This approach does not involve increasing price sensitivity of consumers and providers, but does offer some potential short-term savings. The Foundation is promoting two benefit administration strategies: second opinion programs and prior authorization (or pre-certification) of elective hospital admissions.

Second opinion programs are designed to increase consumers knowledge. They encourage or require consumers to obtain another opinion prior to surgery to confirm the need for surgery, and to assure that other alternatives have been considered. Consumers can ignore the second opinion and still retain coverage. The rationale behind a second opinion is that differences of opinion and style of practice exist among physicians and that by providing additional information to patients, some may choose not to have surgery.

The empirical research on second opinion programs show that they are effective. They show that 10-30% of surgeries are not confirmed. Of those with non-confirming opinions, 65-80% did not have surgery. There also appears to be a substantial sentinel effect, namely, a lowering in the overall rate of recommendation for surgery. There is one critical caveat about second opinion programs. It is clear they either have to be mandatory or contain strong economic incentives to get the second opinion. Otherwise, no one gets the second opinion.

Prior authorization programs are designed to review the necessity of proposed non-emergency hospitalization prior to admission. They rarely deny coverage. They do the following: (a) steer patients to the most cost-effective setting, (b) establish provisional lengths of stay, (c) avoid unnecessary early admission, (d) enforce second opinion requirements, and (e) assure that testing is done before admission, if possible. Anecdotal evidence suggests these programs can reduce hospital days by 10-30%.

Both of these benefit administration strategies, however, have some limitations. They do nothing to change the financial incentives of either consumers or providers. As a result, they can generate substantial consumer and provider resistance. Also, these strategies react to, rather than alter, incentives. Over time, providers may make adjustments or develop counter strategies, such as increasing unit prices or finding new things to do. Nevertheless, these strategies do seem to be effective, at least in the short run.

Foundation activities to promote second opinion and prior authorization programs include the following:

- Studying the existing programs and defining the tenants for success of these programs.
- Educating the major employers and unions on the benefits and limitations of these programs.
- Providing technical assistance to third parties interested in developing these programs.
- Developing an information base from third party claims data to help in administration of these programs (e.g., length of stay distributions for each procedure).
- Encouraging the Utah Professional Standards Review Organization to develop a strong second opinion and prior authorization program for the private sector.

Accomplishments of the Foundation

Since it began operation in 1980, the Foundation has worked to implement each of the above strategies in Utah. Some of its activities merely involve building a consensus for competition, while others have involved providing technical assistance to specific providers. Since 1980, the Foundation has accomplished the following:

- It has gained a credible presence in the community. The media, local businesses, third party payers, state government, and providers look to the Foundation for information and advice on implementation of cost containment strategies.
- It has developed and published vital information on the magnitude of the cost problem, its underlying causes, and a comprehensive cost containment strategy.
- It has created increasing support for the market approach among business, third party payers, and providers, and unqualified support form the Governor.

- It is providing consumers with information on how to use health care services cost effectively, including comparative hospital prices and nine other consumer information pamphlets.

- It is inducing change in the design of health benefit plans through direct efforts with third party payers, employers, and state government. Many of the Foundation's strategies are being put into effect in private and public health benefit plans.

- It is inducing change in the administration of health benefit plans. The Utah Professional Standards Review Organization is now developing several benefit administration programs for use by private purchasers, including the following: concurrent utilization review, prior authorization of elective admissions, and second opinion surgical consultations.

- It is inducing changes by providers through direct efforts and indirect influence. Hospitals an physicians are beginning to look at ways in which they can compete for patients on the basis of cost.

  - Two new Health Maintenance Organizations (HMOs) have started.

  - Several physician groups and hospitals are seriously considering development of HMOs and Preferred Provider Plans.

  - Hospital staffs are looking at ways to reduce lengths of stay, reduce prices, and expand ambulatory alternatives to inpatient care.

- It has initiated development of a data base to help third party payers and employers identify efficient providers and utilization patterns.

- It has created increasing support for necessary legislative changes at the state level.

After three years of operation, it is clear that progress is being made toward a competitive market in Utah. However, such progress is slow and much remains to be done.

Senator HAWKINS. Thank you.

Mr. Carballo?

STATEMENT OF MANUEL CARBALLO, SECRETARY, EXECUTIVE OFFICE OF HUMAN SERVICES, COMMONWEALTH OF MASSACHUSETTS

Mr. CARBALLO. Madam Chairwoman, it was a former Member of this body, Senator LaFollette, that once called the States the laboratories of the Nation, and I am pleased to see that the Senate is proceeding again in that spirit.

I wish to report briefly on what we have been trying to do in Massachusetts. I have submitted for the record extended comments, and I will abbreviate them here.

Let me begin by saying that the core of the Massachusetts strategy has been very close and active cooperation with the private sector and business sector activities in trying to control health care costs.

That resulted, through the very active participation of the Business Roundtable and the health care industry in Massachusetts, in the adoption of a change in Massachusetts laws called chapter 372 which placed acute care hospitals on a prospective budgeting system.

What that means is that we have moved away from retroactive reimbursement of costs incurred. We have, in essence, adopted a method of saying to the hospitals that we will pay up to a particular limit and no more. Based on that limit, we are projecting approximately 2 percent gain a year on productivity savings and reductions in the costs of hospital operations in Massachusetts during the coming 3 to 6 years.

While it is very early, and too early to assess the success of the program—it only went into place in October of last year—at the moment we are still projecting savings over the course of the legislation in excess of half a billion dollars.

The other feature which distinguishes chapter 372 and our effort in this area is that it is totally comprehensive. It includes all payers. It includes medicare, under a waiver from the Federal Government. It includes medicaid, the State-supported program. It includes private insurors, and it includes Blue Cross and Blue Shield.

The net result is that by having a statutory allocation of costs among all payers, the substantial problem of cost shifting—namely of moving costs from one payer to another—has essentially been eliminated and is one of the very real and immediate benefits of the legislation.

We are, of course, concerned that any such approach toward budgeting might in some way limit access, and we have established a monitoring mechanism to ensure that there is in fact no denial of access to hospital care as a result of this.

But, generally speaking, I think it fairly reflects the testimony of the preceding panel that one major part of the problem of health cost growth has been hospitals, and Massachusetts has indeed targeted that element of the cost dilemma through this legislation.

The second part of Massachusetts' strategy is the revival of the health planning function and its reinvigoration, and most especially focusing on problems of capital cost and capital cost containment.

The statute which I mentioned, chapter 372, deliberately omitted capital costs from the limitations imposed, essentially to recognize the requirement to maintain debt service. It also allowed the passing through of operating costs associated with capital costs that were approved by the determination-of-need process.

During the preceding 2 years in the preceding administration, approximately 96 percent of all applications for determination of need were approved, in some way substantiating Professor Reinhardt's statement to the effect that it is not a question that determination of need has failed but rather that it has not been tried, and that the determination of need, to succeed, requires a great deal of political courage and valor.

In Massachusetts, that courage has been bolstered, I believe, by the active participation of the business community, labor, and others, in an absolutely unified front on the part of all major sectors of the political spectrum, to the effect that capital costs must be curtailed.

That has been initiated through the establishment in the State health plan of a limit on capital costs associated with increases in operating costs. Roughly speaking, what that means is that we will allow only such capital projects to be approved as will not increase operating costs in excess of 1.5 percent of the total hospital operating budgets during a particular year.

That translates into roughly $157 million in capital investments during the current year, which may be contrasted with the roughly $600 million in capital applications pending in the determination-of-need process. So while $157 million is a significant number, it clearly is a substantial reduction in what was planned on the agenda in capital investments.

Finally, I would add that the third essential element of Massachusetts' effort to contain health costs is the element of prevention and the emphasis to be placed on sound and well-developed and well-proven programs such as the women and infant children [WIC] program, the EPSDT program, and other preventive efforts directed indeed, as the previous speaker has indicated, at changes in lifestyle having to do with smoking and drinking and exercise and eating. In that area we are indeed encouraged by the action of this committee to move toward reinforcing the Federal commitment to preventive health and would certainly only urge that that commitment extend to funding deliberations with regard to the alcoholism programs and to preventive health programs generally across the board.

We continue to spend a great deal on the curative side of medicine and relatively little on the preventive side of medicine.

With that, I would be happy to answer any questions you may have.

[The prepared statement of Mr. Carballo follows:]

PREPARD STATEMENT OF MANUEL CARBALLO

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Manuel Carballo
Secretary

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Mr. Chairman, Senator Kennedy, Members of the Committee

Good Morning. My name is Manuel Carballo. As Massachusetts Secretary of the Executive Office of Human Services under Governor Michael Dukakis, I appreciate the opportunity to report to you our progress in controlling health care costs and some proposals for your consideration.

No one here needs a detailed introduction to the health cost problem. We all recognize its gravity nationally, and particularly in the states we serve. Massachusetts, however, has over the years, experienced especially high health care costs. Some salient facts follow. Massachusetts residents pay twenty-six percent more than the national average per day in a hospital and forty five percent more per hospital stay. By 1981, the Massachusetts per capita expenditure for health was thirty-three percent above the comparable national figure. Medicare hospital payments per enrollee in Massachusetts were forty-one percent higher than the national average. Since 1977, Medicaid expenditures, the single largest state budgetary item at over one billion dollars, have doubled. So has the cost of a state employee's Blue Cross package, from ninety-seven dollars to two hundred and fifteen dollars. The Massachusetts Municipal Association reports a twenty-five percent average increase, this year alone, in health insurance premiums that municipalities must pay for their employees. These staggering figures spare no one, including business. For one business, the Norton Company in Worcester, Massachusetts, from 1981-1982 health care costs shot up more than one-third while company earnings plummeted from ninety five million dollars to 19.3 million dollars. For another, the Morgan Construction Company, Blue Cross premiums increased four hundred and twenty-eight percent between 1972 and 1981, from seventy-one dollars to insure an employee to one thousand five hundred and nine dollars per employee.

Inaction on the health cost problem means more than high premiums and tax burdens. When a business must devote over fifteen hundred dollars for a single employee's health costs, it is evident that the health cost problem exacerbates unemployment as well, by making it financially unattractive for business to hire new employees or recall laid-off ones.

In Massachusetts, we have declared intolerable and unaffordable, any further inaction.

We have been able to structure a system of savings that preserves quality and ensures access. It embraces several critical and fundamental tenets on which, I believe, any national model for health finance reform should be based: 1) that the health cost problem does not originate with the poor, unemployed, or elderly, all of whose need for and right to health care equals our own: 2) that its resolution should not, indeed, cannot, occur by imposing on those groups undue burdens that blame the victim, such as the steel worker who suffers from the residue of Federal mismanagement of the economy: 3) that slowing the unabated increase in health care costs requires regulatory incentives coupled with competitive and creative institutional management.

The cornerstone of our effort to combat health costs is a recently enacted state law, Chapter 372 of the Acts of 1982. The law had as its major sponsor, the Massachusetts Business Roundtable, around whom coalesced an unprecedented and committed coalition of state government, both legislative and executive; industry, hospital and medical; and, insurer, both Blue Cross and commercial. Together, that group set the parameters of the hospital cost containment effort embodied in Chapter 372, and petitioned the federal government for a waiver whereby Medicare, as a payer of about thirty-five percent of all hospital costs in Massachusetts, would also participate in this bold and dramatic new effort to control hospital costs. Following the imposition of several qualifying conditions regarding permissible rates of increases in costs, free care and bad debt obligations and other reimbursable and non-reimbursable expenses, Medicare granted a three year waiver. Massachusetts now has a prospective budgeting system for its hospitals to replace the anachronistic and inflationary cost-based retrospective reimbursement system.

Conceptually, the system is simple and sound. It applies to all acute care hospitals, basic management principals of business practice. Whereas the old system encouraged hospitals to inflate patients' bills wherever possible since the hospital was virtually guaranteed payment by either the patient's insuror or, in the case of Medicare or Medicaid enrollees, Government, the new system establishes for each hospital, a specific operating budget. That budget is based generally on its 1981 costs factoring in certain savings and productivity incentives. If a hospital's expenses exceed the predetermined budget, the hospital pays the difference; if they spend less than the budget, they keep the savings. Because this system includes the full participation of every hospital payor, cost shifting among payers is prevented whereby different people would pay different prices for the same services in order to compensate the hospital as it saw fit. I would note that the national system of diagnostically related groupings proposed by the Administration for Medicare, and enacted earlier this year, does not eliminate this systemic flaw of cost-shifting. Clearly, the kind of financial risk inherent in 372, from which hospitals were previously immune, combined with significantly less inappropriate governmental intrusion, induces hospitals to manage prudently. The State will, on a limited basis, monitor hospital performance to guard against potential abuses or abrogation of their responsibility to patients and community.

Implementation of this system began on October 1, 1982, making it a bit premature to announce any major findings or savings, although we do project savings of about five hundred million dollars over what we otherwise would have paid absent 372. But while the transition process has not been painless, neither has it been traumatic. I believe hospitals are finding that there is ample room to cut waste and inefficiency without sacrificing quality of care or access to needed services, despite scattered allegations otherwise. In an era of diminished resources, hospitals must learn to conserve. Fortunately their learning curve is rising and shows no sign of a plateau.

Indeed, one of the things we have learned is that a true statewide system to save costs needs other features that complement Chapter 372 and correct some of its oversights. Although 372 revolutionizes reimbursement of hospitals and creates powerful initiatives for efficient management, that law ignored the issue of capital construction and expensive expansion of hospital facilities. Because 372 treats as a permanent supplement to a hospital's predetermined budget, increased costs attributable to new capital construction projects, new beds became a major loophole through which hospital budgets and our state health bill may continue to climb. Not only must we pay the interest and depreciation costs on new capital construction, but every dollar of capital construction generates an additional thirty cents of operating costs which we also must pay. It is for this reason that we have reinvested our efforts to strengthen a system of health planning empowered to prevent construction of excess and unnecessary beds and facilities.

Sophisticated principles of health planning have enabled us to determine that there are limits on both the need for and affordability of capital construction. Last month the Statewide Health Coordinating Council, a consumer-provider balanced health advisory group to the Governor, issued a State Health Plan which shows an excess of approximately 3,300 hospital beds and contains, among its blueprint for health care, an explicit formula which limits statewide capital construction for hospitals based on the projected operating costs. As an example of how it would work, consider the following: In Massachusetts, there are now pending over 600 million dollars in hospital requests for new construction. While many of these proposals may have considerable merit, there is just no way we can pay for all of these projects, the costs of which would be reflected in bigger hospital budgets and, ineluctably, higher premiums and taxes. We must, instead, prioritize projects within the limits of affordability and endorse only those projects that conform to regional and statewide health needs. My administration intends to use the State Health Plan as a proactive rather than a reactive process, and thereby ensure a reasonable and targeted distribution of limited resources. As applied to the 600 million dollars in pending proposals, the State Health Plan's "Affordability" formula would limit construction to a statewide total of $167 million dollars, which is in itself an enormous sum, but still less than one-third what hospitals are requesting.

I am working very closely with two agencies within my Executive Office to further implement the health planning affordability limit, or cap, if you prefer: the Department of Public Health, which has statutory responsibility to issue or deny certification of hospital requests to expand and build facilities; and the Rate Setting Commission which has overall authority not only to establish hospital budgets, but perhaps more importantly, to approve or deny the contract governing Blue Cross payment of hospital bills as well. Under Chapter 372, this Blue Cross hospital contract defines the costs that Medicare, Medicaid and private insurers must bear. We will, therefore, look to that contract among other administrative and legislative means to address capital costs and other concerns about hospital cost containment. In conjunction with Chapter 372, the cap on capital construction should satisfy the prerequisites of a statewide system able to slow the steady rise in health care costs.

While we have, in Massachusetts, adopted an aggressive agenda to contain health costs, these efforts will prove futile absent an equally aggressive effort at the national level to help prevent the illness and infirmity that hospitals must treat. Regrettably, there is little evidence of this; in fact quite the opposite is true. What has emerged from the administration is a sustained retrenchment in federal support of preventive and primary care programs (we have suffered losses of over thirty million dollars in Massachusetts) such as the efficacious WIC program which provides essential pre and post natal nutrition and health care for pregnant women and their children. The administration would be wise to reconsider their policies and reestablish programs that redistribute resources consistent with proven public health principles of prevention. While health care institutions offer the perpetual promise of technological care, prevention offers the justice of universally applied health protection. Taking the beaten and myopic path of cutting prevention and primary care programs is, perhaps, politically expedient, but it leads, inevitably to the same dead end of deficits, massive cutbacks and inequities that states must cope with and correct. We can pay now or we can pay considerably more later. By focusing on primary care and prevention of disease now, we can obviate the need for costly curative care later.

Throughout the nation, in the area of health care services, states must meet many challenges, an explosion of costs, an increasing needy population, diminishing resources, and a retreat in federal support and initiatives. Massachusetts has responded by mobilizing a unique and mutually beneficial bond between the business community and state government, and by asserting, through the health planning process, the leadership role of state government. With continued federal support of state health planning and determination of need, and with the federal government reaffirming its role in a partnership for prevention, we can responsibly honor our commitment to provide quality health care for all.

Thank you very much, and I shall be happy to answer any questions you may have.

Senator HAWKINS. Thank you.

Dr. Nelson, in your opinion, what areas should receive the Federal Government's attention to curbing inflation in health care costs while we maintain the quality of care?

Dr. NELSON. We think that most of those types of initiatives should come from the State level. We are concerned about the—

Senator HAWKINS. Can you think of anything that should come from the Federal level? And then list what comes from the States.

Dr. NELSON. To answer your question most fairly, Senator, the health policy agenda of the American people, from the AMA, is addressing this subject in a broad way by all parties, including representatives from the Government, Department of Defense, VA, and so on. I believe that this collaborative effort—it is my impression that on our committee, which has 28 people, including some from those two, that the role of the Federal Government would be very limited.

Senator HAWKINS. The role of the Federal Government would be very limited.

Should health care reforms take place at the State level or on the local level, in the cities?

Dr. NELSON. The local level would be our choice, simply because there is such a divergence.

In our State, for example, along the Wahsage front, we have a large urban population. However, there are a great number of people who live in very small communities, and rules we may make there may not be applicable.

Senator HAWKINS. Could you describe what would happen in your State if an all-payers program were initiated at the Federal level?

Dr. NELSON. We think that is not a good idea because we think that what would happen is there would be a continuing upcoding of the diagnoses, and so on, so that in effect you would end up perhaps spending more money rather than less.

Senator HAWKINS. Some economists believe that prospective payment should be applied to other providers such as doctors. Do you think that is a good idea?

Dr. NELSON. I think that the truthful answer to that question is that the amount of money which the doctor accounts for in his own personal gain is a very small part of the whole picture. I am not afraid of that system; I am simply concerned that the same type of thing would occur, again upgrading the diagnoses. So I think that is not a particularly good suggestion.

Senator HAWKINS. There are some who claim that technology has increased health care costs, and last week HIMA said that some, perhaps most, technology is cost effective, and the cost problem is really only involved when the technology is overutilized. As a physician, do you agree with that statement?

Dr. NELSON. No, Senator, I do not. There are so many things that are helpful.

When I was a medical student, Hodgkins disease was nearly uniformly fatal. In many instances, it is over 90 percent curable now because of the new changes that have occurred.

One that everybody likes to talk about, the CT scanner, is a very expensive piece of equipment, but when used appropriately, it can save all sorts of invasive processes against the body that don't have to be done. It is very efficient. We must not stifle these types of new technology. We need them. We have got to make our people stay healthy.

Senator HAWKINS. In your mind, is it ever overutilized?

Dr. NELSON. Yes, ma'am.

Senator HAWKINS. You are a member of the Utah Health Care Cost Foundation's board. Can you briefly describe the activities of the foundation and why it was initiated?

Dr. NELSON. Thank you. It was initiated because of a mandate from the local government in our State to do a study which was called the Lujan report by the Lujan commission. One of the suggestions was that this foundation be established. It has been established, and it is funded by private funds from the Hartford Foundation. It has gone into many of the things—many of the statements which I have made are statements that the Cost Management Foundation would make.

Some very interesting things have been done, however, one of which was publishing in the local newspaper, by diagnosis, 20 common procedures which were done and the cost at each hospital. You can imagine the tremendous concern on the part of each hospital administrator when he knew that was going to occur. There was such a difference, sometimes three and four and fivefold, Senator—not percent, five-fold—in what was done.

The fact is that this has helped in some areas to reduce the expenditures by reducing the types of things done—significantly in one area that I am very familiar with, since I am an obstetrician-gynecologist, that of the hysterectomy. It was much less expensively done at our teaching hospital than in some of the private hospitals where there was not a house staff.

Some of the things we found were not what we expected to find. Another thing that is very significant that the foundation has done is the publication of a pamphlet for our consumers or patients, which I like to call them still, on how to use the system well.

Senator HAWKINS. Did you ever run into the problem of the hospital ordering tests that the doctors did not?

Dr. NELSON. In our hospital, that would not occur. I don't recall that being a problem specifically. We don't have standing orders; those have been abolished. Each patient has orders each particular time that patient is admitted, so the hospital does not do that.

Senator HAWKINS. Was it ever a practice?

Dr. NELSON. It was practiced, yes.

Senator HAWKINS. That has been stopped?

Dr. NELSON. We didn't think it was fair.

When I was chairman of our hospital cost containment committee, we found a lot of things that we could do to decrease costs.

Senator HAWKINS. Surely.

Dr. NELSON. A simple example: We saved $60,000 in 1 year by simply ordering type and screen for whole blood rather than type and crossmatch. It made no difference at all in the quality of care; in fact it made the blood available to more people. It was $60,000.

Senator HAWKINS. That is a lot of money when you are trying to get it up here, I would like you to know.

Mr. Carballo, should health care reforms take place at the Federal level or at the State level or the local level?

Mr. CARBALLO. Well, I am inclined to think that the fact of the matter is that there must be a cooperative effort by both levels and that there indeed is a central role for the Federal Government. Ironically, President Reagan seems to agree, since, in the New Federalism proposal, he proposed the movement of the medicaid program up to the national level, along with the medicare program, which rather ironically would seem to establish the preconditions for national health insurance.

I think the fact of the matter is that if we are to have a strategy for dealing with health costs, we need to do several things: First of all, find an equitable method of financing health costs for those people who cannot afford it. That is a burden that, generally speaking, I think, can only be carried by the Federal Government.

Second, we must have, at the local level, regulation, policies, and direction, policy direction, which can move toward cost containment that is sensitive to the needs and the access and the requirements of States and local government.

I think finding the correct blend of those two goals will be the task of the next decade.

Senator HAWKINS. In your testimony, you describe the Massachusetts program, which regulates hospital admissions on an all-payers basis. Do you recommend such an approach to a State such as Utah, which has successfully developed a marketplace oriented toward competitive pricing and aware consumers?

Mr. CARBALLO. Well, I would not necessarily recommend it for Utah. I think Utah should be experimenting through its own needs to determine what is effective. I think we have many different roads to try to develop means of dealing with cost containment.

Massachusetts, for instance, has in fact a very large teaching hospital component which makes it rather unique in a variety of ways in terms of the cost of hospital care, in terms of the burden borne by the health care system in Massachusetts as, in essence, an educator for a great many of the health care consumers and providers across the country.

But what I would say is that ultimately one must have a system which does address all payers. Moreover, what we have had in the past is a system which, by providing payment for certain types of services—for instance, hospitalization but not necessarily for preventive care—or for certain types of persons—for instance, persons who are employed and receiving benefits under some sort of employment scheme but very little for those who are unemployed and therefore not receiving health insurance benefits—that we have distorted the health care system and the efficiency of the health care system by creating a system of hidden cross-subsidies. One group is often subsidizing another group, and without necessarily having an overt policy decision as to the nature of the subsidy.

So I guess I would say that my bottom line would be that ultimately we need to develop a strategy that is very much conscious of the problem of all payers and equitably allocates costs among them.

Senator HAWKINS. How have you dealt with the capital expenditures and the allocation of resources under your State program?

Mr. CARBALLO. Basically, what we have begun to do is to use the State health planning process to do more than simply review individual applications solely on the basis of the need for each individual application.

Our prior and existing regulations which were the bases for determinations of need indicated that every particular project would be weighed on its own merits but that, in addition, we would take into account in approving or not approving a particular project its aggregate impact on health care costs within the Commonwealth, and that would include its aggregate impact on public payers, third-party payers, and all others.

Part of the problem that was faced prior to this year is that aggregate impact, of course, was an interesting phrase, but it did not have a specific quantitative measure. By the act of the legislature in adopting chapter 372 and creating a basis of what was an appropriate basis for reimbursement of operating costs, it established, in essence, a vehicle for us to link the amount of money which the legislature determined, as a matter of public policy, should be spent on hospitals to the amount of capital costs that would impact on operating costs.

As a direct consequence, I believe, of that decision, the State health planning body set the limit on capital costs that I indicated to you. An example of one of the resulting decisions, and a rather dramatic reversal from prior practice, was that recently there was an application submitted by a very well known hospital clinic for expansion which would have cost $25 million in capital but added

$20 million in operating costs in conjunction with the $25 million in capital. That application was denied, and I do not believe that that would have happened as little as 4 to 5 months ago.

Senator HAWKINS. How does your program cover inpatient and outpatient services?

Mr. CARBALLO. The chapter 372 provisions of statute apply only to inpatient services in acute care hospitals.

Senator HAWKINS. What types of alternative delivery programs are being established to reduce the costs of health care?

Mr. CARBALLO. We are very deeply engaged in expanding a whole variety of activities. In the medicaid area, in particular, we are very interested in the area of managed health care plans. I think what we will see over time is the development of a continuum of these managed care plans ranging from managed care simply in terms of having case management by individual physicians to the more elaborate and complicated model of health maintenance organizations, with a whole variety of mixed organizations in between.

One very interesting venture that is currently under discussion in the Boston area is a proposal that has been put forward called the Commonwealth Health Care Corp., a joint venture of the teaching hospitals in Boston in conjunction with the community health centers of Boston to provide for medicaid a system of managed care for medicaid recipients. That is something which is promising and which we are exploring to see whether that is a model that should be adopted.

In addition to that, of course, during the coming years, we expect to be moving very strongly on the preventive front, most especially in the area related to perinatal and children's care, low birth weight. We are extremely distressed in Massachusetts, as is the case nationally to a similar degree, by the fact that a nonwhite child is twice as likely to die at birth as a white child. The State health plan has set as one of its objectives the reduction of that disparity.

There would seem to be absolutely no justification in the quality of our health care system or in the goals of our society to accept the notion that for some reason nonwhite children should have less of a prospect for good health and life than white children.

Senator HAWKINS. How is home health care treated under your State program?

Mr. CARBALLO. Home health care is financed in a variety of ways, not only through the medicaid and medicare programs, but in essence we actually have more of a continuum in that than many other jurisdictions.

Through our secretariat of elder affairs, we have financed, largely through title XX funds, although not exclusively, over a score of home care corporations which are nonmedical home care corporations, and these in turn complement the home health corporations which are made available through medicare and other means.

In addition, we have four categories of licensed nursing homes, one of them being a resthome category, which recognizes the fact that this is another area in which we need a continuum of services with different degrees of intervention from medical care professionals. So our objective is not only to have home health care as a reality but indeed to have as a reality the availability of home care that is essentially less medically involved.

I should add that there is also a concern that with regard to various types of programs that currently exist such as SSI or, indeed, in our own general relief programs, that we do not unintentionally create a disincentive for persons to take care of persons in their own homes.

For instance, under current SSI law, we now have a situation in which, if a person lives alone, that person will receive a grant at one level; if a person lives with another person, that person will have his or her grant reduced on the assumption that living with another person makes some of that other person's income available to that person. That would seem to me to create a rather strong economic disincentive for people to take care of their own at home.

[The prepared statement of Mr. Clayman follows:]

Health Care Cost-Containment

Statement by

Jacob Clayman
President

National Council of Senior Citizens
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Before the U.S. Senate Committee on Labor and Human Resources

May 25, 1983

Mr. Chairman, I am Jacob Clayman, President of the National Council of Senior Citizens. The National Council represents over 4.5 million elderly persons in all 50 states through over 4,500 clubs and state councils. Our organization was founded during the long struggle to adopt a Federal health insurance program for the aged. Over the years we have worked toward the goals of a better life for senior citizens--one with dignity, as well as income and health security.

The cost of health care has a significant impact on the elderly's income and health security. It affects their ability to pay for the mandated cost-sharing under Medicare as well as for the many necessary services not covered by Medicare. The price of health care also affects the capacity of the Medicare program to adequately finance the beneficiaries' medical needs.

The uncontrolled medical inflation rates of the last decade have raised Medicare program costs, eroded Medicare coverage, increased beneficiaries' out-of-pocket health care expenses, and now threaten the solvency of the Hospital Insurance Trust Fund. Because of these consequences, as well as the impact that uncontrolled medical inflation has on all citizens and on the economy, the National Council of Senior Citizens believes that controlling the cost of health care for all people warrants the Congress' immediate attention.

Mr. Chairman, medical inflation has justifiably alarmed members of the Administration and the Congress. It has inspired them to seek cost-reducing strategies. They are correct to do so, however, the policy adopted thus far has been misdirected, ineffective and unfair. These public decision-makers seem to define "cost-containment" as reducing the Federal government's health care spending. Budget cuts in Medicare, Medicaid, and other health programs have been labeled "savings."

During the last three fiscal years, while the Administration advocated budget cutting and the Congress avoided wrestling with the powers of the health care system, medical inflation has left a trail of devastation. Health care prices have been growing at a rate triple that of the CPI (1982 medical inflation was 11 percent versus a CPI of 3.9 percent). Medicare costs continue to rise at about 18 percent annually. The elderly beneficiaries' out-of-pocket health care burden has grown to an estimated $1,500 annually. Federal costs have been shifted to private payors at a rate of $6 - 7 billion per year.

Mr. Chairman, this is not cost-containment. It is budget cutting and shifting of Federal costs with no attempt to make the health care system economically efficient. The Congress and the

Administration have failed to pursue true cost-containment derived from needed control over the inflation-driving incentives across-the-board. Yet, as more and more people of all ages find affordable health care a luxury, the President and the Congress continue to avoid tackling medical inflation and instead push for further cuts in Medicare and other public health spending.

The FY 1984 budget proposals for Medicare and Medicaid, and other proposals such as a tax cap on employer-paid health insurance, add another dimension to misdirected Federal "cost-savings" policy. These proposals presume that the consumer of health care can play a key role in cost-containment. Advocates of increased cost-sharing claim that a cost-conscious consumer will demand fewer allegedly unneeded services and somehow pressure doctors and hospitals into cost-efficient behavior.

The Medicare beneficiaries' contribution to these "cost-containment" schemes would be to pay a higher Part B premium and deductible and a new Part A co-payment. The beneficiaries' therefore would share not only part of the Federal government's Medicare costs, but also a large portion of its responsibility for cost-control.

Such proposals will not produce an economically efficient health system. They will simply force people to pay more for their care, or forego receiving medical attention. The principal decision-makers in the health system, primarily the providers, whose decisions feed inflation, will have no incentive to change their behavior.

Consider these conditions of the health care marketplace:

Physicians make 70 percent of the decisions. It is the physician's judgment, not that of the patient, which determines hospital admission and use of diagnostic technology, prescription drugs, laboratory and radiological tests, ancillary services, institutional vs. out-patient care, etc.

The health consumer is rarely, if ever, a participant in the decision-making process which leads to hospital construction and expansion or equipment purchases, significant causes of rising medical costs.

The Health Care Financing Administration reports that the rise in health care spending between 1967 and 1978 is attributed to:

- increased prices (50 percent)
- increased intensity of services provided (36 percent)
- aging of the population (12 percent)
- increased utilization, or demand (1.2 percent).

In view of these facts, will cost-savings strategies aimed at the user of health care have any significant impact on the causes of inflation? We doubt it. The causes of medical inflation will hardly be touched, but the people who need health care will suffer the greatest burden.

For the elderly, the recent attempts at Federal cost savings have only increased an already heavy burden. The aged need more comprehensive health care services than the under-65 population, and the expenditures they incur for care are three times greater than those of younger persons. However, Medicare covers only 44 percent of the elderly's medical expenditures due to rising medical costs and an inadequate benefit package.

The Medicare beneficiary now pays 20 percent of his or her income on health care--as great a proportion as was spent before Medicare was enacted. Yet health cost-containment to the Administration and many members of Congress means Medicare budget cuts, and increased beneficiary cost-sharing.

Again, I suggest this is not cost-containment. Cost-sharing is merely a euphemism for cost-shifting. It is ironic that many members of Congress are now expending considerable energy trying to figure out where they can apply cost-sharing, that is, increase beneficiary out-of-pocket costs, so that the least burden will be felt. Not only does this approach ignore the level of beneficiaries' medical needs, it also asks the wrong questions. The Congress should be asking: will beneficiary cost-sharing render the health system efficient? Will it change provider behavior? The answer to both questions, we believe, is no.

Therefore, we contend that increased beneficiary cost-sharing will fail as an attempt at cost-containment. It will instead shift Federal costs to the elderly and disabled Medicare beneficiary and allow inflation to continue. Such a policy will force Congress to return for "savings" year after year to the Medicare beneficiary and to other recipients of Federal health programs.

The National Council of Senior Citizens considers the Administration's and Congress' current approach to be poor public health and budget policy. There are better ways to save Medicare dollars. Since Medicare spending reflects the inefficiency and uncontrolled spending in the larger health system, cost-saving plans must begin with the entire health care system.

Unless and until the costs of our health care system are brought under control, no amount of cost-sharing or other budgetary devices will help Medicare. Furthermore, the cost to the beneficiary of such ineffective strategies would be too high.

The threat of Hospital Insurance Trust Fund insolvency should not press the Congress into precipitous budgetary action. There is sufficient time for Congress to adopt carefully developed and equitable methods outside of the budget process to assure Medicare's future protection. The opportunity exists for the Congress to make Medicare program improvements so that the beneficiary and the trust funds will be better off.

We believe that Congress has the obligation to control the rising cost of health care for the benefit of all citizens, and that this can be acccomplished through a sensible constructive approach. Many plans are under consideration and others are being developed. Senator Kennedy has proposed S. 814, one of the most reasonable plans to be brought forth in this Congress. There will be others.

The plans that can succeed as true, equitable cost-containment are those which instill economic efficiency into our health system. They are targeted to the causes of rising costs and to the real decision-makers in the system. With a firm Federal commitment, these plans call for prospective payment to assure that the providers take the financial risk for their actions. The plans inlcude all payers and all providers to avoid cost-shifting. The plans that can succeed also assure quality of care and preserve access to services, without increasing the financial burden on the beneficiary.

The promising plans also require the states to participate in cost-control programs. The experience and success of all payor state plans, such as those in New Jersey, Maryland, New York, and Massachusetts, are valuable. Federal legislation is needed to encourage all states to develop their own plans.

Are such cost-containment plans possible? The NCSC believes they are, but not as long as the Congress seeks short-term budget savings regardless of the cost to people.

We believe that across-the-board savings should be the primary objective of Congressional cost-containment initiatives. The Medicare program will benefit as a result. For example, consider that three out of four program dollars are spent on hospital care. Across-the-board cost-containment that reduces hospital costs, rather than shifting them, will generate savings for Medicare and for private insurors, individuals, employers, and others who now bear shifted costs.

Changes within the Medicare program could also be made to generate savings while improving the benefits package to more closely meet the elderly's medical needs. For example, plans which seek more extensive coverage of non-institutional services will better use Medicare dollars now spent on unnecessary and expensive institutional care when alternative services would suit the beneficiary's chronic care needs more appropriately.

Such plans represent better use of the Medicare dollar. This, we believe, is a direction that Congress should pursue, along with health system-wide plans to slow the rising cost of health care. These two approaches will assure savings without sacrificing citizens' access to the quality, appropriate health care service they need. We urge the Congress to take this approach to saving health care dollars.

Senator **Hawkins**. Thank you so much. We appreciate your participation here today.

We would like to call our fourth and final panel. I understand one of the members, Jacob Clayman, was unable to remain for the full time.

We will call Mr. Jack Owen, the executive vice president of the American Hospital Association; Mr. Lawrence Morris, who is senior vice president of Blue Cross/Blue Shield; and I understand we have lost Mr. Jacob Clayman, who is president of the National Council of Senior Citizens. He had to leave. We will insert his testimony for the record, and, also, we will submit questions to Mr. Clayman and ask him to respond to those questions, and it will be included in the hearing record.

Mr. Owen, would you begin, please?

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. **Owen**. Thank you, Senator Hawkins.

For the record, I have submitted a statement from the American Hospital Association, which I will not read. In the interest of time, I would like to summarize what I believe are the important points and, then, if there are any questions, I would be happy to answer them.

I think, as I have listened to the hearings held both last week and this morning, certainly the reasons for health care inflation have been stated and repeated, so there is no reason for me to go into them. The expansion, certainly, of the dollars in medicare has grown tremendously since 1965.

However, as I listen to testimony about the dollars that are being spent, it bothers me that very few people bring out the fact that the number of people over 65 that we are taking care of now has increased dramatically since 1965. Although we look at the medicare pool in terms of the total number of dollars, we have to remember that the great number of people over 65 that are now using it has grown tremendously. That is part of the problem, which is not due primarily to hospital inflation or any other factor other than just general utilization of services.

Certainly we have had general inflation in this country. We have seen more utilization of services by the elderly, who consume many more services—hospital and health care—than the younger population. And we have seen some changes in technology which were referred to by your previous two witnesses.

I would like to spend a couple of minutes talking about why we think the prospective payment system is preferable to a regulatory system in health care.

First, there seems to be some misunderstanding about the prospective pricing system enacted by Public Law 98-21. I have heard some people comment that it is not a regulatory system and it is too competitive. It needs to be brought out that the prices that are being set by the new diagnosis-related groups [DRG's] are Government prices, not prices set by hospitals, so that already there is an element of regulation or determination by Government in that.

There is a pool of money that is used. The money is divided up by DRG's, and the hospital is not out setting its prices for the medicare patient but living within the prices established.

Now, why is that a good system? We believe it is good because it provides some incentives that have never been apparent or active in any other system that Government has used. Before, medicare had always been a cost reimbursement system, and as long as the hospital spent money, the Government paid for the costs that were utilized.

Under this new prospective payment system, we have an opportunity to improve the productivity in our hospitals. As we improve productivity and as the price stays at a given rate, the hospitals have an incentive to do better and to gain more money.

We see a reduction in intensity by doing this. For the first time we are beginning to look at each case to see how many resources go into each patient who is being cared for—how many tests, how many days of stay. All of these factors are now being examined in a different light, where as on the old cost system, whatever those tests were, whatever the length of stay was, were paid for by the Government. So that is a step toward what some people might call a competitive situation.

We are seeing better management of patient services by such a system. Because I spent 20 years in New Jersey where the DRG system was in effect for 5 years, I have experience with what the Federal Government is moving into.

We see whether a patient belongs in an acute care hospital or whether he belongs in a day care center or a surgery center or a medicenter or in a nursing home—or in a home health care situation that you asked about a few minutes ago. Whatever is chosen, price is a factor.

We are beginning to reassess what the investment is in expensive technology. Can every hospital have all of the most expensive technology? By setting a DRG price, the Government is going to force hospitals to deternine whether they can afford to do this. We tried it with planning, we tried it with regulation, and it has not been too effective. This may be the way to move.

Certainly we are seeing the development of referral agreements that are moving patients back and forth between less expensive means of caring for them. So it looks very helpful.

But we need some additional changes if we are really going to be successful in this. We must have some incentives for consumers as well as providers. You can put all the incentives you want on the hospital side, but if the patient has no incentives to pick out the most inexpensive—yet effective—way to be treated, he is going to continue the way he has. We have seen this time and again.

One of the concerns we have with the deductible that is presently being considered for medicare is that it is a flat deductible rate. It is based on an old cost reimbursement system. No matter which hospital you enter, the deductible will be $304 in 1983, $350 in 1984. We think that this ought to be examined in relationship to the price so that a consumer, a patient, will say, Where can I go where I will spend fewer of my own dollars, or where can I go that will cost less so that I do not have to pay additional dollars?

The next step has to be to provide more incentives for the consumer. We think that, in so doing, Government and others, too, have to look at ways in which there is adequate payment for these alternative services. We cannot ignore the fact that with the graying of America, as it has been said so many times, we are going to have so many more people who are over 65 and so many more using nursing homes. We are just beginning to see that develop, and the cost in the nursing home is going to be far greater in the long run than it is going to be in hospital services.

That makes essential greater cost consciousness among consumers, among the patients and the providers. We have to have a program which will provide for some predictability, some equity, and some simplicity so that patients will understand what is the best way to proceed to get their health care.

We have endorsed the administration's budget proposals on greater cost sharing of medicare. We would like to see such cost sharing on the basis of pricing, not on a deductible, so that people begin to choose which is the best health care service to seek.

We would like to see some voucher systems. I know there are some experiments in Florida. We would like to see those publicized and examined. Maybe you could do that, Mr. Chairman, as you look at various factors, because I believe the voucher is the first step toward a competitive model.

And we are very much in support of a cap on the deductibility of health insurance premiums. We are in favor of that because we cannot say to the elderly, the over-65 population, that they should participate in the payment for their health care, but all the working people have no reason to participate because they are protected under some tax advantage that they have. We would like to see the cap passed, and we would like to see the revenues from it dedicated perhaps to pay for health care for the unemployed, because that is a problem that we are facing.

If we could tie those two together, I think this Congress could do a most important thing for all of us.

I would just close by saying that I believe the importance of the communication between Congress and the industry has been greater in this past year than in many previous years. I think we are working better together. We as hospital people understand the problems that you have with the medicare trust fund, with social security. Hopefully, most of the Senators and Representatives are beginning to understand the problems that we have in delivering the care which you are promising so many people.

I think that the significance of this and last week's hearings, and our continuing dialog, will go a long way in trying to solve some of these very important problems.

With that, I would close and thank you very much for giving me the opportunity to be here.

[The prepared statement of Mr. Owen along with responses to questions asked by Senator Hatch follow:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION BEFORE THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES ON HEALTH CARE COSTS

May 25, 1983

SUMMARY

Enactment of the Medicare and Medicaid programs in the mid-1960s expanded access to health care services, with a spiralling of program costs: from $4.7 billion in 1967 to $46.6 billion in FY 1982 for Medicare and from $1.5 billion in 1967 to $17.4 billion in FY 1982 for Medicaid. Factors such as general inflation; utilization of services, particularly by the elderly; technological advances; and intense use of services have contributed to the significant increases in health costs.

Two solutions have been proposed to reduce such health inflation: competition and regulation. The competitive approach is reflected by prospective pricing, enacted this spring to bring cost incentives to the Medicare program. Other competitive approaches include Administration proposals for restructuring of Part A of Medicare, experimental use of vouchers, and a "cap" on deductibility

of health insurance premiums, all of which the AHA generally endorses, and copayments for Medicaid recipients, which the AHA opposes.

The regulatory approach is exemplified by S.814, the Health Care Cost Control Act of 1983, a proposal that the AHA views as failing to address the factors contributing to health inflation, lacking cost incentives, and relying too heavily upon government control.

In favoring competition, the AHA is committed to working with the Congress in bringing cost consciousness to providers as well as consumers of health care.

INTRODUCTION

Mr. Chairman and members of the Committee, I am Jack W. Owen, executive vice president of the American Hospital Association and director of its Washington office. The AHA is the principal organization of this nation's hospitals, with approximately 6,300 member institutions and more than 35,000 personal members.

Thank you for giving me the opportunity to present the AHA's views on an issue of great concern to hospitals: rising health care costs. In my statement, I plan to address expansion of access to health services by federal programs; factors affecting health costs, such as inflation, utilization, technology, and intense use of resources; Medicare prospective pricing, a competitive approach to reducing increases in health costs; other competitive approaches; and the Health Care Cost Control Act, a regulatory approach to reducing costs.

FEDERAL ROLE IN EXPANDING ACCESS TO HEALTH SERVICES

The rate of increase in health costs is demonstrated by a rise in national health expenditures from 4.4 percent of the gross national product in 1950 to 9.8 percent in 1981. A significant portion of the increase is due to the creation of the federal Medicare and federal-state Medicaid programs in the mid-1960s, which expanded access to health services for the aged and poor. Increasing enrollments in these programs in the late 1960s and the 1970s were highlighted in 1973, when Medicare was broadened to include the disabled and those with end-stage renal disease.

Open access to health care services was the overriding philosophy, encouraged by cost-based payment of hospitals and charge-based fees for physicians, with limited consumer cost sharing. With increased availability of services offered by hospitals and with greater use of those services by beneficiaries, program costs spiralled, from $4.7 billion in 1967 to $46.6 billion in FY 1982 for Medicare and from $1.5 billion in 1967 to $17.4 billion in FY 1982 for Medicaid.

According to one estimate, total federal outlays for health are expected to increase about 12 percent a year, from $74 billion in FY 1982 to $144 billion in FY 1988. Of these outlays, the Medicare and Medicaid programs are projected to consume about 90 percent, with other health services, education and training, research, and consumer and occupational health and safety accounting for the remainder.

With such growth, the philosophy of open access--without incentives for reducing the rate of increase in health costs--has begun to be challenged, leading to a search for balance between services and costs in the 1980s.

FACTORS AFFECTING HEALTH COSTS

Inflation

Inflation in the prices of resources used by hospitals has accounted for a substantial part of the overall increase in hospital costs. Such inflation occurs for various reasons: increases in wages and fringe benefits that hospitals, which are labor-intensive, pay to employees; higher prices for medical and housekeeping supplies, drugs and pharmaceuticals, food, fuel, and other items that hospitals purchase; and stepped up resources--new staff, supplies, and capital--that hospitals use to accommodate added admissions, particularly of the elderly, with greater intensity of services.

The effects of inflation, in terms of supply and other prices, were heightened in the recent past, but may be abating due to changes in overall economic performance. At the same time, hospital wage levels have risen more rapidly than wages in the general economy. For example, the proportion of highly skilled--and consequently, higher-salaried--professional staff has grown, due to the need for such personnel as medical records and utilization review staff and specialized nurses to work in intensive-care and other special units.

Behind the statistics--on wages paid, supplies purchased, and resources provided--are other factors that help explain the increases in total costs, such as utilization, technology, and intense use of resources.

Utilization

The expansion of third-party coverage, particularly through the Medicare and Medicaid programs, has--as indicated--substantially increased the demand for health care and has stimulated the choice of hospital care by discouraging the use of lower-cost alternatives to hospital services.

The rise in demand has been especially pronounced in the over-65 population. Approximately 26 million people 65 and older--95 percent of the elderly population--are enrolled in Medicare, contrasted with about 50 percent in that population group who had health benefits in 1967. By the year 2000, approximately 32 million persons are expected to be Medicare recipients.

Part of the increase in the use of hospitals by the elderly is the result of an aging of the population, the so-called "graying of America." Between 1970 and 1980, the population of persons 65 and older grew by 27.9 percent, while the total population increased by 11.4 percent. In 1980, persons 65 and older represented 11.3 percent of the population, compared to 9.8 percent in 1970 and 9.2 percent in 1960.

This 11.3 percent consumed nearly 33 percent of health care expenditures, a proportion that is expected to rise as the population ages. For those over 65, hospital expenditures are $869 per capita, compared with $370 per capita for those between 19 and 64.

Moreover, a shift in care patterns for the aged has been occurring, as organized health systems assume some responsibilities once accepted by families. The dramatic rise in nursing home care, for example--a doubling per 1,000 elderly in nursing homes from 1963 to 1977--may be as much due to changes in social patterns as to coverage under Medicaid of skilled nursing facility (SNF) and intermediate care facility (ICF) care, and to a lesser extent, under Medicare for SNF care.

Technology

With growing utilization has come accelerating technology, as a proliferation of intensive care units, development of artificial organs, creation of electronic implants, and innovation in new kinds of surgery have both saved lives and increased hospital costs. However, some procedures, such as drugs used in psychiatry and certain surgical procedures, have decreased costs, by reducing inpatient care.

While new technology has offered greater access to certain services, it has required extensive investment in equipment and specialized personnel. Community demand for full services may result in increased costs along with greater convenience. Moreover, technology may be utilized, even if its benefit is far from certain, because it is available. Overall, technological costs must be balanced with benefits to patients and communities, in terms of improvements in health status.

Intense Use of Services

Utilization and technological changes have meant more intensive use of services, not only of personnel--resulting in increased hospital employment and subsequent labor costs--but also of treatment protocols. Since the Medicare program began, there has been a substantial reduction in average length of stay, particularly among the elderly, with greater use of ancillary services for each inpatient day. As a result, overall intensity of hospital services has risen.

COMPETITIVE APPROACH OFFERED BY MEDICARE PROSPECTIVE PRICING

Background

Two solutions have been proposed to the problem of rising health care costs: competition and regulation. Competition is a fairly new concept in dealing with health costs. Its objective is to reestablish economic incentives that will lead providers and consumers to consider price and cost when making management decisions and using health services, respectively.

The prospective pricing system for Medicare inpatient services enacted as part of P.L.98-21, Social Security Amendments of 1983, illustrates a competitive approach. Toward such an approach, the AHA last year proposed an interim prospective pricing system, based on average per-discharge payments. This system, while addressing the need for short-term savings in the Medicare program, was to have been an initial step in implementing a full prospective pricing plan for the long term.

Such a plan was necessary to bring structural reform to Medicare, because tinkering with the program's reimbursement system was no longer appropriate or workable. What was needed was a strategy of innovative pricing balancing financial rewards and risks, so that hospitals would be paid adequately for efficient and effective management and penalized for inefficient and ineffective performance.

Congress, in P.L.97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, directed the Administration to draft its own prospective pricing proposal. Following presentation of the Administration draft to Congress in late December, the AHA further refined its own plan. The AHA then engaged in negotiations on prospective pricing provisions with both the legislative and executive branches, and worked closely with both in getting prospective pricing enacted. Although the AHA has some concerns about the prospective pricing system established by P.L.98-21, the Association views initiation of prospective pricing as a positive step.

Provisions

Effective with each hospital's fiscal year beginning on or after October 1, 1983, Medicare payment for inpatient hospital services will be on the basis of prospective prices, with separate prices established for each of 467 diagnosis-related groups (DRGs). These prices will replace the cost-per-case limits on Medicare payments created by TEFRA. The DRG system will be phased in over a four-year period, with separate urban and rural national DRG prices scheduled for the fourth year. During the preceding three years, payment will be a blend of hospital cost-per-case amounts, regional average prices for the DRGs to which patients are assigned, and national average prices for patient DRGs, with separate prices for urban and rural hospitals.

The system will apply to all hospitals except long-term, children's, psychiatric, and rehabilitation facilities and distinct-part psychiatric and rehabilitation units of general hospitals.

There will be special consideration of indirect and direct medical education costs, capital expenses, and atypical cases.

Cost Incentives

Following are some of the strengths of the competitive approach of Medicare prospective pricing, in terms of how hospitals can use services more efficiently.

First, because Medicare revenues will be fixed, hospitals will have an incentive to increase productivity. Improvements in productivity entail review, and adjustment when necessary, of such aspects of hospital operations as management policies, staffing patterns, supplies, and work scheduling practices.

Second, under prospective pricing, hospitals will have an incentive to reduce the growing intensity of hospital care. Shorter lengths of stay and reduced utilization of ancillary services can, if combined with reductions in the resources used to produce services, result in substantially lower costs. The ability of hospitals to manage intensity is, of course, limited by several factors. Among the most important are patient needs and professional standards of medical practice. However, management of intensity, particularly the intensity with which "high cost services" are used, offers considerable potential for reducing the rate of increase in total costs.

Third, hospitals will have an incentive to manage patient services. Specifically, hospitals will be looking seriously at the development of lower-cost alternatives to acute inpatient care. Conversion of beds from acute care to skilled nursing care may produce substantial savings, as may the development of home health and other outpatient services. Combined with intensive discharge planning and patient education, the lower cost alternatives to acute inpatient treatment can reduce total lengths of stay and result in patients being in the lowest-cost setting consistent with their medical needs and preferences.

Fourth, hospitals will have an incentive to reassess investment in expensive technology. The acquisition of technology for specialized equipment, nursing units, and staff will to a significant degree be limited by the ability of the hospital to generate sufficient revenues to recover the generating expenses of the new services. Hospital payments will reflect the number of patients admitted that need and use the services for which costs were incurred. Hospitals will, therefore, limit acquisition of new technology to those areas in which the total volume of patients is sufficient to recover the fixed costs of the service, or in which the investment reduces other generating costs by more than the additional cost of the new service.

Finally, hospitals will have an incentive to develop regional referral arrangements to ensure access to needed specialty services. As the expensive technology offered by a hospital is limited to sufficient volume to recover fixed costs, hospitals lacking certain services will have to develop close relationships with facilities that provide such services. The result of such relationships will be continued access to essential services, with lower overall costs to the Medicare program.

Additional Changes

Even with these incentives, the full benefits of prospective pricing will not be realized unless they are consistent with the incentives influencing other providers of health care and consumers of health services. As prospective pricing is implemented, changes needed to make the system more competitive will become apparent. For example, reforms are needed to ensure adequate payment rates for alternatives to acute, inpatient hospital treatment, such as skilled nursing or home health care for patients discharged from acute units. For another example, rewards are necessary for consumers who choose outpatient over inpatient services, when appropriate, and who select "lower priced" providers.

OTHER COMPETITIVE APPROACHES

The Administration, in its FY 1984 budget proposals released January 31 of this year, recommended the introduction of incentives into federal health spending in four ways, in addition to enactment of prospective payment: restructuring of Medicare Part A to provide greater cost sharing by and catastrophic illness protection for beneficiaries, experimental use of vouchers as an alternative to Medicare, mandated copayments for Medicaid recipients, and limits on the deductibility of employer-paid health insurance premiums.

Restructuring of Medicare Part A

In its budget proposals, the Administration proposed that Medicare hospital benefits be restructured, so that beneficiaries would pay a deductible equal to one day of hospital care ($350 in 1984), 8 percent ($28) of the deductible for days 2 to 15, and 5 percent ($17.50) of the deductible for days 16 to 60. In order to provide protection to beneficiaries, the Administration recommended that unlimited catastrophic illness coverage be offered after the 60th day of hospitalization. For SNF care per illness, Medicare would cover the first 20 days, with copayments of 5 percent of the hospital deductible for days 21 through 100.

Currently, Medicare covers 90 days of inpatient hospital care per illness, with an additional 60 days of lifetime reserve. After an initial deductible of $304 (rising to $350 in 1984), there is no deductible for days 2 through 60. Daily copayments of $76 for days 61 through 90 and $152 for lifetime reserve days are required. For SNF care, the copayment rate for days 21 through 100 is 12.5 percent, higher than the Administration's proposed figure.

The AHA supports the Administration's intent in recommending restructuring of Part A as an important step toward cost consciousness by having beneficiaries share in the initial costs of treatment. Moreover, such restructuring would provide catastrophic illness protection, thereby removing the financial burden--and the fear of devastating costs--from the most severely ill beneficiaries.

However, the AHA believes that any restructuring should take into account the recently enacted prospective pricing legislation. First, the Administration's proposal is based on the per-diem cost of a hospital room. It should relate cost sharing to the DRG rate. Second, the Administration's proposal is based on all beneficiaries' paying the same amount of out-of-pocket expenses. It should relate cost sharing to the hospital providing the services, so that a beneficiary would have an incentive to choose a lower-priced facility. Third, the Administration's proposal is based on incentives for early discharge. The DRG-based prospective pricing system already includes such incentives.

Experimental Use of Vouchers

Another Administration proposal would inject competition into the Medicare program by allowing beneficiaries to accept alternatives to Medicare coverage. Under the Administration plan, beneficiaries could choose to receive 95 percent of the per-person costs of the program, in the form of a voucher for purchase of a private health benefits plan.

This experimental use of vouchers, which would cost an additional $50 million in FY 1984 but which could produce savings in future years, is in line with the AHA's call for long-range structural reform of the Medicare program. As long as traditional insurers, as well as health maintenance and preferred provider organizations, would be included as participants and as long as voucher plans would be required to provide benefit packages at least equal to Medicare's, the AHA endorses the proposal.

Further, the AHA favors the expansion of the voucher proposal to include hospitals as eligible health benefits organizations. As the centers of health care services for their communities, hospitals are uniquely qualified to plan and provide the type and range of health services needed and desired by their communities.

Copayments for Medicaid Recipients

The Administration proposes that the categorically needy pay $1 per inpatient and $1 per outpatient visit and that the medically needy pay $2 per inpatient and $1.50 per outpatient visit, under the Medicaid program.

While the AHA supports encouragement of cost consciousness among consumers in the use of health services, it questions whether imposition of nominal copayments on Medicaid recipients would serve this goal. Enactment of the proposal could mean that Medicaid recipients, with limited financial resources, might forego needed care or not make the copayments, the latter placing hospitals in double jeopardy: to bear the administrative burden of trying to collect the fees or to shoulder the financial burden of absorbing increased bad debts, or both.

'Cap' on Deductibilityof Health Insurance Premiums

The tax subsidy on employer-paid health insurance premiums is, in effect, the "third-largest government health program" after Medicare and Medicaid in terms of cost to the federal government, according to one economist. Although not an entitlement, the subsidy also contributes to health inflation that plagues both Medicare and Medicaid by providing an incentive for employees to choose more health insurance than they would if they were using taxable income.

The Administration would like to generate $2.3 billion in FY 1984 revenues by placing a cap on this subsidy: limiting the deduction to $70 per month for individual coverage and $175 per month for family coverage.

In addition to raising tax revenues, such a cap would help remove the insulation that separates consumers from actual health costs. The theory is that exposure to costs would make consumers more cost conscious, thereby encouraging them to demand more cost-effective care and to use less costly services.

The AHA, agreeing that the tax subsidy of private insurance has contributed to inflation in health care costs, supports a cap on premiums. Reducing the rate of inflation means addressing not only Medicare and Medicaid outlays, but also private sector health spending, due to interrelationships between them.

Guidelines for Cost Sharing

For consumers, changes in cost sharing can be used to promote more careful use of health care and selection of providers. When options for beneficiary cost sharing are being considered, the AHA believes that the following guidelines should be followed: First, consumer cost sharing should promote cost consciousness in the decision to choose inpatient hospital care or a less costly alternative, such as outpatient treatment. Second, it should be predictable, so that consumers are aware of any out-of-pocket liability at the time decisions on provider and service are made. Third, it should be equitable, so that consumers are not denied access and seriously ill patients who require intensive care do not experience undue financial burdens. Fourth, it should be simple, as well as easy to understand and administer, so that consumers are not confused and administrative costs increased.

REGULATORY APPROACH PRESENTED BY THE HEALTH CARE COST CONTROL ACT

A second approach to the problem of rising health care costs is regulation. The Carter Administration, in the 1970s, attempted to "control" hospital costs by working to enact H.R.2626, its hospital cost containment bill. The Carter approach--imposition of mandatory caps on hospital inpatient revenues--was rejected by the House in November 1979. Various arguments were used to defeat the proposal: its failure to address the causes of health inflation, absence of incentives for reducing the rate of increase in health costs, and reliance upon government and dependency upon red tape.

S.814's Provisions

S.814, the Health Care Cost Control Act of 1983, introduced by the ranking minority member of this Committee, Sen. Edward Kennedy, is reminiscent of the Carter bill in that it would impose new limits on hospital inpatient revenues and require civil penalties--up to 150 percent of overcharges, lodged in escrow accounts--of hospitals exceeding the limits. It would freeze maximum hospital revenues at the base level, and adjust them upward only on the basis of market basket inflation. However, it would permit passing through of all wage increases, whether or not they were justified on the basis of prevailing wage rates. It would not provide for changes in patient case mix, but would reduce the cap on revenues if a hospital eliminated services--even underutilized services, unless approved by the state--in an effort to keep its costs within the revenue ceiling.

In a second phase, S.814 would "encourage" each state to establish its own prospective payment program (not necessarily DRG-based), according to strict criteria, and give the Secretary of Health and Human Services the authority to impose a program on any state without one after October 1, 1984. This approach--state rate review--has not been demonstrated to be effective, particularly when compared to the type of prospective pricing enacted by P.L.98-21.

In addition to other problems caused by the regulatory approach--failure to address the causes of health inflation, absence of incentives, and reliance upon government control--state rate review shows unfair preferences for certain payers, which creates inequities; can result in rates so low that hospitals deplete their capital resources, jeopardizing their future financial stability and their ability to serve the poor; and attacks revenues rather than costs.

Failure To Address Health Inflation

Like the Carter "cap" legislation, S.814 does not address the causes of health inflation. Under S.814, Medicare would continue to pay hospitals on the basis of retrospectively determined costs, subject to the system of cost-per-case limits created by TEFRA, unless a state adopted a system of rate review for all payers. Aside from undoing the progress that prospective payment legislation represents, S.814 does not take into account the utilization of health services, particularly by the elderly; role of technology (aside from establishing a short-term Advisory Commission on Health Care Technology and Procedures to examine technological advances); and intensity of resources that have contributed to increases in health costs.

Absence of Incentives

S.814 does not recognize that consumer cost-sharing has been shown in studies by the Rand Corporation and others to have a powerful effect on the demand for health services. Nor does it view consumer demand as a tool that can equitably be used to shape the demand for services, by emphasizing low-cost alternatives and deemphasizing those that result in high costs. Nor does it take into account the willingness of hospitals, other providers, and patients to contribute to solutions to the rising rate of health costs.

Reliance upon Government

This legislation, too, puts the federal government at the fore, at a time when the trend is toward greater state and local control and more responsiveness to local needs. In its first phase, it would mandate federal control over hospital costs. In its second, it would force states to set up their own systems or accept the Secretary's design. States establishing their own plans would have multiple requirements to meet, including coming in under the federal cap and percentage controls on total inpatient hospital revenues.

As a result, this legislation, like the Carter measure, would create extensive red tape, at considerable administrative cost. Not only would it mix retrospective cost and pricing systems--requiring significant bureaucracy--but it would extend into every aspect of health care delivery. From hospital revenues to physician fees to laboratory costs, it would apply requirement after requirement that would have to be implemented and monitored.

Since the inception of Medicare and Medicaid, the hospital industry has been the focus of increased government regulation, a factor that the President acknowledged when he signed Executive Order 12291, to eliminate regulations that are burdensome or unnecessary. The AHA has actively participated in such elimination, whether it has involved excessive reporting and inspection, multiple centers of authority or accountability, or lack of incentives for hospitals to achieve effective delivery. One reason the AHA supported enactment of a DRG-based prospective payment program for Medicare was its potential for reducing the regulatory burden on hospitals in this nation. Enactment of S.814 would reverse the laudatory trend toward deregulation, which prospective payment--if given a chance--may continue.

CONCLUSION

Mr. Chairman, the AHA commends you and members of this Committee for examining the reasons for rising health costs and for seeking solutions to their deflation.

This Committee's hearings on health costs occur at an historic time, when a first step--Medicare prospective pricing--has been taken to reduce the rate of increase in health costs. Through the Committee's deliberations, subsequent steps can be identified, such as adjusting the prospective pricing system to enhance competition in health care delivery and in establishing incentives for health consumers, e.g., through greater cost-sharing.

The dialogue has begun, and the AHA is committed to its continuation: to work with this Committee and other Committees in the Congress to bring cost consciousness to providers as well as to consumers.

QUESTIONS FOR MR. JACK OWEN, AMERICAN HOSPITAL ASSOCIATION

1. There are many in Congress who feel that Federal efforts should be directed solely at the providers of care. Do you feel that the exclusive problem rests with the providers? And would encouragement of a voluntary effort, as was done in 1978-1982, be of benefit in reducing health care costs?

Not only providers but also consumers of health services must have incentives to reduce rising health costs. To approach the supply side without addressing the demand side would be inconsistent and incomplete. Under prospective payment for inpatient services, hospitals will have incentives to reduce costs. Consumers of such services must also have incentives to consider cost in using health care services.

Cost consciousness is not effective under traditional cost-based reimbursement. Proposals the Administration has suggested and the AHA has endorsed include experimental use of the voucher as an alternative to Medicare; limits on the deductibility of employer-paid health insurance premiums; and greater cost-sharing by Medicare beneficiaries of Part A deductibles, with catastrophic protection. In terms of the latter, the AHA believes that such cost-sharing--in terms of services provided by individual providers--could be related to prices in the prospective payment system.

The AHA continues to believe that voluntary action can contribute to reducing health inflation. The AHA and some other organizations that were involved in the formal Voluntary Effort continue to work on this issue. A group, headed by John Dunlop, Lamont University professor at Harvard University and former Secretary of Labor, and including the AHA, American Medical Association, AFL-CIO, Business Roundtable, Blue Cross/Blue Shield Association, and Health Insurance Association of America has been meeting for over a year to stimulate local activities through coalitions involving providers and other parties in addressing the cost-effective use of health care resources.

2. Do you anticipate that the recently enacted prospective payment legislation will affect the way hospitals provide services? Do you feel that this system will effectively reduce hospital costs and make hospitals more cost conscious in their delivery of care?

While the AHA has some concerns with the prospective payment system initiated by P.L.98-21, the Social Security Amendments of 1983, it views prospective pricing as a positive step in addressing the increase in Medicare outlays for hospital inpatient services.

Such prospective pricing offers hospitals an incentive to increase productivity, to develop lower-cost alternatives to the offering of inpatient acute care, to reassess investment in expensive technology, and to develop regional referral arrangements to ensure more efficient use of needed specialty services. These incentives should work toward reducing the rate of increase in Medicare hospital costs and causing hospitals to be more cost conscious. However, incentives for hospitals must be matched with consistent incentives for consumers.

3. With the shift of payment to a cost per case basis rather than a cost reimbursement basis, what will hospitals do to pay for uncompensated care costs?

Because Medicare is continuing its traditional policy of not recognizing uncompensated care costs, the shift to per-case payment should not in itself change hospital provision of uncompensated care.

I would like to note that AHA, in its prospective payment proposal, proposed that hospitals accepting the Medicare fixed price as payment in full for acute inpatient services receive an automatic increment in computing their price if they serve high portions of Medicare and low-income patients. Congress did not include this provision in P.L.98-21, choosing instead to provide for an adjustment for hospitals serving high volumes of such patients. The AHA is presently monitoring closely the Department of Health and Human Services' development of regulations to implement the prospective pricing regulations, to see how it handles this adjustment. Traditionally the Medicare program has picked up bad debts for Medicare patients, while uncompensated care outside the program has been financed by other hospital revenues, generally at severe financial detriment to hospitals with significant charity care and bad debt burdens.

4. Could you explain why you do not support existing health planning laws?

The AHA until late May opposed federal domination of health planning, and advocated instead planning at the local level. However, in late May, the AHA Board of Trustees changed the Association's position regarding the federal role in state and local health planning. The board, in considering amendment and extension of existing federal health planning legislation, stated that any approach should be consistent with the following principles:

o elimination of federal sanctions under which public health service funds can be denied to states not in compliance with federal requirements;

o inclusion of the sunset date of October 1, 1986 in any federal health planning legislation;

o allowance for states to participate voluntarily in the federal program to fund state certificate-of-need (CON) programs;

o determination by states of whether local planning units should be formally involved in CON review;

o establishment of a higher CON review threshold, e.g., $5 million, in the federal planning law to encourage more streamlined CON review programs and to ensure that states with CON review thresholds at or below this amount be eligible for federal planning funds; and

o limitation on federal involvement in local planning to a matching grant program with minimal federal requirements.

Senator HAWKINS. Thank you, Mr. Owen.

Mr. Morris?

STATEMENT OF LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. MORRIS. Thank you, Madam Chairman.

My name is Lawrence Morris. I am a senior vice president of the Blue Cross and Blue Shield Association.

The association is the national coordinating agency for 99 Blue Cross and Blue Shield plans.

We have submitted a written statement for the record, and with your permission, I will simply review some of the key points in that statement.

First, the health care delivery system and the health benefits market have changed quite substantially in recent years. Thus, cost containment has emerged as a major focus of competition, and we want to underscore that point. It needs to be appreciated so that policies reinforce rather than inhibit the effect of competition in the control of health care costs.

Cost containment programs need to have quite clear objectives. Ours include trying to be a prudent purchaser of health care, developing flexible strategies to deal with variable local needs and problems, and coordinating payment methods in appropriate utilization and benefit programs. We do not see any single solution to the problem of cost containment.

We describe in our statement several specific approaches which can contain health care costs when they are carefully designed and carefully implemented. They include prudent payment based upon contracts with providers, utilization control, medical necessity evaluation, benefit design, alternative delivery systems, and health planning.

We stress the need for ongoing evaluation both of individual programs and the strategies of which they are a part. One frequent strategy these days is to zero in on specific cost problems—for example, the misuse of inpatient settings for certain surgical procedures—and to focus on solutions to those problems.

Our programs have succeeded, in our view and in the view of others who have studied them, in cutting hospital utilization, in shifting more care to less expensive settings, in moderating capital costs, and in promoting alternative delivery systems. The fact remains that we have had to increase premiums substantially. This is partly a function of factors over which we have little or no control—an aging population, the effects of general inflation on the health care economy, and the accelerating development of medical technology.

We observe that the cost consequences of these factors are magnified by a popular conception that more care is better care and for a national propensity for litigation that promotes a costly defensive form of medicine.

Nonetheless, we expect that the growing sophistication of medical necessity evaluations, the development of tighter contractual arrangements, improved means of acquiring and applying data, and other developments will permit Blue Cross and Blue Shield plans to be increasingly effective in dealing with health care expenditures. This is simply a competitive necessity.

We believe that competitive forces will play a progressively more important role in containing costs, so long as they are not neutralized by inappropriate regulation. This should certainly not be construed as blanket opposition to regulation. We recognize the need for Government intervention when the market fails to meet the needs of society.

Nevertheless, we are concerned by some proposed policies, in particular those calling for the imposition of tax caps and all-payer rate regulation systems.

We strongly advise that the Congress not impose a tax on employee health benefits. We see several undesirable effects. A tax cap would provide incentives to emphasize expensive inpatient services rather than the potentially cost-containing outpatient benefits. It would have a disproportionate impact on lower income workers and risk discouraging the employment of older, handicapped, and less healthy individuals.

Furthermore, managements and unions might elect both to maintain comprehensive benefit plans for employees in need of such benefits and to set up lower cost, lower benefit options. If that were to happen, a tax cap would promote adverse selection and undermine the broad sharing of risk that is necessary if the less healthy groups are to be adequately covered.

A few points on all-payer rate regulation systems. Such programs may very well be appropriate in some settings, and where reasonable consensus on the approach has been developed among providers, payers, carriers, and policymakers. In many cases, however, an all-payer approach can stifle cost control arising from competitive forces. Evidence that this approach works over the long term and under diverse local conditions is still not very conclusive.

One argument for all-payer systems is that they eliminate cost shifting. Payers that pay the reasonable cost of care for their beneficiaries are not cost shifting. Yet under all-payer plans, those payers would generally pay more to cover the costs created by the business and underwriting practices of others.

To conclude, we feel that the Blue Cross and Blue Shield organization has made considerable strides in controlling health care costs through a variety of programs. While there is still more that needs to be done, we are committed to continuing effective existing cost-containment programs and experimenting with new ones. Such initiative is certainly essential in our market.

Madam Chairman, that ends my review of the statement. I would be pleased to try to answer any questions you may have.

[The prepared statement of Mr. Morris along with responses to questions asked by Senator Hatch follows:]

PREPARED STATEMENT OF LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and Members of the Committee, I am Lawrence C. Morris, a Senior Vice President of the Blue Cross and Blue Shield Association, the national coordinating organization for the 99 Blue Cross and Blue Shield Plans. We appreciate this opportunity to share with you our experience in developing and implementing programs to control health care costs. This experience is based both on our private business, in which Blue Cross and Blue Shield Plans serve nearly 80 million Americans, and on our public business as intermediary or carrier for 20 million Americans covered under Medicare, Medicaid and CHAMPUS.

As you are aware, the health care world has changed considerably since the Congress established the Medicare and Medicaid programs in 1965. The focus of concern among public policy makers, employers and insurors has shifted from assuring access to care to containing the costs of care. Indeed, much of the competition in the health services and health benefits markets now revolves around the ability to offer cost containment. The steady growth of HMOs, the recent exploration of preferred provider arrangements, the increased popularity of cost sharing benefits, and the proliferation of programs such as ambulatory surgery and pre-admission review testify to employer, insurer, and provider commitment to try new approaches to cost control.

It is important that the rapidly changing nature of health care delivery and of health insurance be recognized as the government evaluates policy options. Otherwise, we risk adopting policies conceived when competition was not a significant factor in health care cost control and perhaps, in the process, inhibiting the effectiveness of competition as a restraint on health costs.

In this testimony, I will discuss three main topics:

1. the objectives of Blue Cross and Blue Shield Plans in designing and implementing cost containment programs;
2. our successes and disappointments in that endeavor; and

3. our concerns about certain proposed government interventions in the health care and health insurance systems.

OBJECTIVES OF COST CONTAINMENT PROGRAMS

In order to stay competitive, Blue Cross and Blue Shield Plans have concentrated on developing effective cost containment programs that are sensitive to customer needs and preferences. We have been guided by the philosophy that cost containment programs should concentrate on eliminating unnecessary costs but should not keep individuals from needed care. Moreover, they should not be unduly restrictive toward providers who fill necessary roles and who may be efficient, but nevertheless, financially distressed. Examples might include hospitals with heavy teaching or charity responsibilities. We are further concerned that cost containment efforts neither undermine good quality health care nor foster adverse selection, which can destroy our ability to make coverage available to poor risk individuals.

In pursuing competitive strategies that serve the multiple objectives of cost control, quality assurance, service accessibility and broad risk sharing, we are guided by several principles.

1. A prudent and reasonable price for provider services is an objective best arrived at through free negotiations between the parties at economic interest. Payment negotiations are most effective at the local level where the interests of both provider and payor can be most fully understood and represented.

2. Focused multi-faceted strategies are needed. No single activity can effectively contain health costs. Nor is any one prime emphasis likely to be suitable in

varying environments with differing problems. Approaches that are effective in some states may not work in others because of differences in provider practice patterns, consumer attitudes, employer preferences, and public policy traditions.

3. An effective cost containment strategy will require that payment incentives to contain costs be matched with benefit packages and utilization control programs that reinforce the payment method's strengths and compensate for its weaknesses. For example, per case payment methods generally should be backed by outpatient benefits and utilization programs that discourage unnecessary short-stay admissions.

4. Insofar as possible, program administration should be simple and consistent with existing administrative structures and processes. The more complex the administrative demands of the program, the more costly it is likely to be and the greater the likelihood of unexpected side effects.

5. Cost containment cannot stop with program design; it has to follow through with attentive implementation, evaluation, and, when needed, program redesign.

This describes our general approach to cost containment. Nevertheless, it is important to recognize that different groups have different needs, different philosophies, and different objectives in balancing access, quality and affordability. The federal government is increasingly becoming a prudent purchaser, and its objectives are reflected in the adoption for Medicare of a prospective payment system based on DRGs. We have generally supported this action. However, we also support the right of unions and management to pursue the prudent purchase of health services based on their particular philosophies, objectives and degrees of commitment, free from unnecessarily prescriptive regulation.

SPECIFIC COST CONTAINMENT PROGRAMS

During the 1970's, when the hospital inpatient admission rate for the United States population under age 65 was rising by about one and one third percentages points a year, the rate for Blue Cross Plan members was falling by about two thirds of a percentage point per year. Studies sponsored both by our organization and others indicate that several Blue Cross and Blue Shield Plan cost containment efforts contributed to this differentiated and downward utilization trend. According to these studies, as well as our more subjective judgments, six cost control strategies have been particularly effective in providing incentives for the appropriate use and pricing of health services. They are:

- Negotiated Payment Arrangements
- Utilization Control
- Medical Necessity Evaluation
- Health Planning
- Benefit Design
- Alternative Delivery Systems

NEGOTIATED PAYMENT ARRANGEMENTS. One way that Blue Cross and Blue Shield Plans contain health care costs is by negotiating contractual arrangements with hospitals, physicians and other health care providers. These contracts are the principal means by which Blue Cross and Blue Shield Plans act on behalf of their members. using the members' combined purchasing power to establish access to services at fair prices.

These contractual arrangements do more than specify the level and method of payment for services provided to Blue Cross and Blue Shield Plan members. At their best, they contain prices, improve utilization, encourage innovation and benefit both our members and those providers who contract with us. The amounts paid under such arrangements reflect what it reasonably costs, or should cost, to serve Blue Cross and Blue Shield patients. They compare to the usually higher—sometimes much higher—charges that providers unilaterally establish.

Not only do such arrangements benefit our subscribers, they also reduce providers' financial uncertainties. Providers benefit from the minimal level of bad debt generated by Plan subscribers, from Plan business practices that reduce administrative costs and improve cash flow, and from Plan underwriting practices that extend coverage to poorer risks and smaller groups, who are thereby able to become paying patients rather than a financial burden to providers or to the community at large.

Negotiated arrangements also serve as the basis for Plans and providers to test new or alternative payment programs. These programs include, for example, the Maxi-Cap prospective payment systems in Rhode Island and Rochester, New York; the capitation programs in North Dakota and Massachusetts; the payment incentives for physicians and hospitals in various states to encourage broader use of ambulatory care, and the preferred provider arrangements being developed and implemented around the country.

UTILIZATION CONTROL. Blue Cross and Blue Shield Plans have developed utilization control programs to assure that their subscribers receive only medically necessary care, and only in the most appropriate and cost-effective settings. These programs produce cost savings, first, through actual claims denials and, second and more important, through processes that educate providers about practice patterns and make Plan expectations clear to them. While our programs have not always worked as well as we would have liked, they have been effective. The obstacles—provider resistance, the administrative costs of these programs, account unwillingness to stand behind claims denial—are diminishing as cost containment becomes a market priority and as recognition grows that you often have to spend administrative dollars to save health benefit dollars.

Compared to a few years ago, utilization data are now more extensive, data analysis is more sophisticated, standards for appropriate utilization are clearer, and programs are increasingly being matched to specific payment methods and benefit packages. These developments are promoting improvements in program effectiveness for Plans and their accounts. Furthermore, important utilization control innovations—such as pre-admission certification—are yielding encouraging preliminary results in selected applications.

For example, Blue Cross of Central Ohio has closely evaluated its program for pre-admission certification of most inpatient hospital admissions. In a comparative study using 1982 data, the Plan found 28% decline in patient days under this program compared only 15% for the entire Blue Cross Plan subscriber group. In Minnesota, an independent peer review program that focused on inpatient psychiatric and chemical dependency care determined that 11 percent of the total days reviewed were medically unnecessary. Only 1,724 claims were involved but this translated into savings of over $300,000. As part of the program, providers assumed financial responsibility for days of care judged medically unnecessary. Altogether, we have many reasons for expecting our payoff from investments in utilization control programs to increase in coming years.

MEDICAL NECESSITY. Since 1977, the Blue Cross and Blue Shield Association has sponsored the Medical Necessity Program that has tackled specific problems in such significant cost generating areas as radiology, laboratory work and respiratory care. In partnership with several major medical specialty organizations, the Program evaluates clinical practice and medical technology to determine which practices and tests are outmoded, of unproven effectiveness, or appropriate only in specific circumstances. Based on the best available medical opinion, guidelines for payment are established to reflect our judgments about what services may require special justification. The program is consciously designed to reconcile the objectives of cost containment and good quality care, and to effect real behavioral change.

A Blue Cross and Blue Shield study of our Federal Employee Program's utilization of 42 target procedures found, for the period 1975 to 1978, a 26% decline in claims paid for the identified diagnostic laboratory procedures. In 1979, we investigated the misutilization of routine hospital admission test batteries. A before/after study conducted by the Oregon Blue Cross Plan found cost savings of $22 per admission from the elimination of routine admission testing. If this $22 per admission saving were extrapolated to all admissions nationwide, these potential savings would be enormous. These good results are in considerable measure a function of the strong working relationship between Blue Cross and Blue Shield Plans, the medical profession, and hospitals to ensure that cost containment goals are achieved in the context of good medical practice. In addition to the Medical Necessity Program approach, a broad range of medical policies are developed by our internal staff and medical and dental advisory committees to foster appropriate use of and payment for medical services.

HEALTH PLANNING. The Blue Cross and Blue Shield organization has supported federal, state and voluntary health planning programs as an important means for controlling capital expenditures and promoting the orderly development of needed health care resources. As is obvious, the cost problem involves not merely capital spending itself but also the operating expenses it generates. One recent study estimated that each dollar in capital investment produces an extra $1.84 in operating costs over ten years (discounted to present value).

Many Blue Cross and Blue Shield Plans have tied payment to provider conformance with planning agency decisions, an action that does hold down total expenses and labor costs per hospital admission. A study by researchers at Johns Hopkins University confirms that these and other Plan actions in support of health planning are associated with lower subscriber admission rates.

The Blue Cross and Blue Shield organization urges you to continue federal support for health planning at the state level. We are alarmed at the growing evidence of a hospital construction surge that is partly a function of doubts that the federal government will maintain a role in health planning and partly a function of providers' desire to position themselves in a more competitive market. A considerable amount of unneeded capital spending may take place before state planning programs and competitive forces are strong enough to compensate for reduced federal planning support.

Eventually, the operation of Medicare's new prospective payment system may discourage unneeded capital investment but we believe it would be unwise for this Congress to rely on this, absent evidence of such an effect. At least for the present, the Congress can help hold down health care cost by continuing federal funding for health planning.

BENEFIT DESIGN. Another promising cost containment strategy is to design benefit packages to shift hospital care to appropriate lower cost settings. Most studies of ambulatory care, home health care and hospice care have found that those services can contain health care costs for some types of patients by substituting for inpatient care. In addition, Blue Cross and Blue Shield Plans have developed innovative benefits for birthing centers, skilled nursing facility care, mental health care, health education and pre-admission testing. By expanding benefits to cover alternative settings and by limiting or withdrawing benefit coverage for hospital services that can be appropriately provided in less expensive settings, Blue Cross and Blue Shield Plans are encouraging the development of lower cost sites of service and are giving consumers incentives to use them.

As just indicated, Blue Cross and Blue Shield Plans are testing various forms of cost sharing for inpatient and outpatient services. Plans are also offering and assessing comprehensive cost-sharing benefit packages. We know that cost sharing can save government and business purchasers money simply by transferring costs to consumers. And cost sharing can discourage unnecessary use of services. However, it may also prompt consumers, particularly those in lower income groups, to forego needed care. Ultimately, cost-sharing focused on specific areas of known misutilization rather than directed uniformly at all types of care may be a more reasonable means of balancing cost, access and quality.

ALTERNATIVE DELIVERY SYSTEMS. We have responded to the competitive health insurance market and the greater need for cost containment by developing alternative delivery systems which change the financial incentives for providers. Blue Cross and Blue Shield Plans are the most prolific developers of health maintenance organizations. Over the past ten years, Plans have invested more than $100 million in HMOs. For the period 1981-86, Plans have committed $159 million for developing or purchasing HMOs. Today, Blue Cross and Blue Shield Plans sponsor 54 HMOs serving 1.2 million members, and they provide services to 25 other HMOs serving 500,000 members.

A number of Blue Cross and Blue Shield Plans are now in the process of developing preferred provider arrangements. We are encouraging controlled innovation in this area to see whether this middle ground between traditional fee-for-service and HMO arrangements can offer a successful blend of cost control, quality of care, and consumer acceptance.

We are aware that there is some interest in federal intervention to promote or regulate these arrangements, but we believe such action would be premature at this point. The preferred provider concept is so new, the specific arrangements are so diverse, and so little is known about their impact on cost, quality and access that a basis for sound policy making has not emerged. For example, it is not clear whether apparent cost savings are due to favorable risk selection rather than incentives for efficiency, and whether discounts really reflect economies of scale or are simply loss leaders that cannot be sustained over time.

Overall, we believe we have had some successes in keeping health care costs below what they might have been without our cost control programs. Our programs have:

- lowered subscriber hospital use rates,
- reduced medically unnecessary procedures and. tests,
- encouraged the provision of care in less costly settings,
- helped moderate capital costs, and
- fostered alternative delivery systems.

LIMITS ON PROGRAM ACHIEVEMENTS

Our cost containment efforts in the private health insurance market have been undertaken as a competitive necessity. Unfortunately, in spite of successes, health benefit premiums continue to rise. To some extent, our problems are a function of our success in improving subscriber access to more and better health care services. Rising premiums, however, are in part a function of factors over which we have no control or only marginal influence. The same is true of government and other private carriers.

The impact of an aging population on health care costs has to be recognized, as does the general inflation in the economy. Due to today's very generous supply of health resources, which has resulted from public and private policies of past decades, we must also contend with the fixed costs of excessive capacity, as well as the excessive utilization stimulated by this capacity.

In addition, scientific and medical advances have created a more intensive and expensive medical care product. This has made it possible for people with serious illnesses to survive longer and, as one consequence, consume more health services. In 1963, one percent of the population was responsible for 17 percent of all medical expenditures, but by 1970 that 1% generated 26 percent of medical expenditures. The figure is now estimated to be around 30 percent. These shifting proportions reflect, in part, the effects of changing medical technology.

The economic effects of changing technological capabilities are magnified by our society's long-standing belief that more health care is better health care under virtually all circumstances. This propensity interacts with the incentives for health care providers to compete for business by adding more facilities, services and equipment. Finally, in our litigious society, many providers have learned to practice a defensive form of medicine that adds much to cost but little or nothing to improved health. Some real progress is beginning to show in certain of these areas. In others, particularly the distribution of expenditures and application of technology, there are inherent questions of policy that we, and probably the Congress, cannot address without a backing in public opinion that simply has not crystallized in this country.

In the future, we expect that the growing sophistication of medical necessity evaluations, the wider application of new benefit and utilization control programs, and the development of tighter contractual arrangements with providers will permit Blue Cross and Blue Shield Plans to exercise more control over some of the less tractable sources of increasing expenditures. We believe that our experience in provider contracting and in applying cost containment programs in diverse settings will help us develop even better capabilities. The forces of competition will lead other carriers and providers to achieve improved results as well.

Nonetheless, no single mechanism, no single organization, in fact, no plausible combination of strategies and organizations, can fully counter all of the cost generating phenomena. This should not be a ground for inaction or excessive pessimism. It is simply a caution against exaggerated expectations of regulatory or competitive, public or private approaches to health care cost control.

PUBLIC POLICY CONCERNS

As a final issue, we would like to voice some specific concerns about proposed government actions on health care costs.

TAX CAPS. As we have testified elsewhere, we consider the capping of the tax exemption for employer-paid health insurance premiums to be poor public policy, either as a cost containment device or a revenue generating device for the Federal government.

Those who favor tax caps argue that such a cap would ultimately result in greater cost consciousness on the part of consumers. We would agree that a tax cap is likely to accelerate the trend to greater cost sharing but we do not agree that it would result in substantial overall cost savings, as distinct from premium savings. It would, however, certainly introduce some severe inequities and distortions which could far outweigh any benefits produced.

Our experience suggests that placing a lid on employer-based health insurance will cause employers to eliminate coverage for potentially cost-effective health benefits, such as preventive care, outpatient physician services and home health care, in favor of retaining maximum coverage for hospital inpatient care and other more threatening medical expenses. A recent study conducted by Gail Wilensky and her colleagues at the National Center for Health Services Research lends support to our experience. These researchers have found that employees with less extensive employer contributions to their health insurance premiums are less likely to have coverage for preventive services such as vision or hearing care, prescription drugs, routine physicals or outpatient psychiatric care. Employees with the highest employer contributions were more likely to have complete coverage for physician care. The one area of coverage which does not seem to be significantly affected by the level of employer contributions is coverage for catastrophic expenses.

It should also be noted that overall, irrespective of income, there is currently extensive use of cost sharing on all services except hospital care. For these reasons, the effect of a tax cap on total health expenditures would be minimal. The greater part of our problem (institutional costs) would remain untouched.

In addition to reducing coverage, or alternatively, employers may reduce premiums by adding more cost sharing to the insurance package and raising the out-of-pocket limits. This would severely compromise the ability of low income workers and their families to seek needed primary care. Results from the Rand Health Insurance Study appear to confirm that increased cost sharing without income adjustments would disproportionately affect those in lower income brackets. Evidence from Canada has also suggested the poor respond relatively more to cost sharing. Because of their higher rates of illness, older, chronically ill or disabled workers would also be subject to disproportionately higher out-of-pocket costs if greater cost sharing were introduced.

A cap on health insurance premiums could lead to the erosion of the insurance principle in any given group. If employers respond to the tax cap by offering employees a choice between lower-cost and higher-cost plans, those who perceive themselves as healthier would likely choose a lower cost, minimal coverage plan whereas less healthy workers would likely choose a more comprehensive benefit, high cost plan. The result of such segmentation of risks, and its financial consequences — which we refer to as "adverse selection" — deserves serious attention, and is discussed in more detail below.

Since prepaid delivery systems tend to offer more comprehensive coverage at a higher average premium, tax caps could impede the development of HMOs and other alternative delivery systems which have been found to provide efficient, quality services at a moderate price.

Finally, tax caps may introduce incentives which would discourage insurers from pursuing any serious attempts to contain overall health care costs. The innovative cost control programs enumerated earlier have been shown to or have promise of holding down health care costs. But these programs, themselves, cost money. When initially introduced, they may cause premiums to rise slightly until the effects of such strategies can take hold. If a tax cap is imposed, employers, employees, and insurers would have less incentive to incur the present and real costs of such programs in the hope of future savings.

Furthermore, under multiple choice, the incentives for cost containment are obscured. Those programs that get the low cost beneficiaries are so advantaged that they do not really need cost containment to attract more subscribers. Those that get a disproportionate share of the bad risks find that the costs of adverse selection cannot be offset through savings from cost containment.

MULTIPLE CHOICE OF BENEFIT PLANS. A second policy direction is the promotion of choice for employee groups through multiple benefit options and for Medicare beneficiaries through a voucher program. The Blue Cross and Blue Shield organization has long-standing experience in multiple choice situations. We have participated since its beginning in the Federal Employees Health Benefits Program, which now offers over 100 options to federal employees through approximately the same number of carriers. We offer both high and standard benefit options as well as HMOs, including an HMO network.

In our experience, the provision of multiple health care benefit options within the same employee group results in a spiral of adverse selection. This may take a long time to develop, but it is inevitable. Younger, healthier employees choose less comprehensive, less expensive programs, leaving the older, less healthy employees in the more comprehensive programs. A recurring cycle of steadily increasing segmentation of risks, leading to greater differences in experience, reflected in a widening spread of premiums, makes it extremely difficult to maintain coverage for the poorer risk groups. For the better risk individuals who have opted for a low cost plan, there may be too little protection when they have an unexpected need for expensive care. The inadequate coverage may, as a result, produce bad debts and added liability for others.

Having said that, we want to emphasize our constructive involvement with alternative structures. Not only are we participating in FEHBP, we are cooperating in experiments to test private alternatives to Medicare. Several Blue Cross and Blue Shield Plans have developed demonstration projects with funding or waivers from the Health Care Financing Administration. Since these experiments are still in process, we believe that voucher legislation should be delayed until the experiments permit conclusions about which approaches work best and what impact adverse selection may have in a Medicare environment. If adverse selection proves to be an important factor, it will be difficult for the voucher system to attract the necessary private commitment. Furthermore, a voucher program will only be able to maintain access to quality care if there is an ongoing, strong financial commitment to Medicare on the part of the government.

ALL PAYOR SYSTEMS. Some are recommending that the government's prospective payment system be extended to all payors. A few states have already adopted rate regulation, in which all payors are required to pay on the basis of rates promulgated under state authority. One rationale given for all payor systems is based on preliminary research findings that rate regulation was successful in moderating the rise in hospital costs. Some recent research, however, has suggested that the rate of hospital cost increases in regulated states is now increasing while the rate is decreasing in non-regulated states. Also, there are questions about whether per capita hospital costs are actually controlled or whether increasing utilization offsets controls on hospital rates. Furthermore, it is not clear what impact rate regulation has on health care quality.

As another rationale for all payor systems, it has been suggested that such systems would control cost shifting. Cost shifting results when one payor does not pay the full cost of care given to its subscribers. By definition, those who do pay full costs do not shift them. When all payors pay the same rate, those payors whose business and underwriting practices lower providers' administrative costs and minimize hospital bad debt are forced to pay the hospital costs generated by the business and underwriting practices of others. In contrast, when market forces are left free to shape payor practice, they provide incentives for payors to differentiate themselves as prudent purchasers and responsible underwriters. In most states, price negotiation acts as one of the competitive forces holding down costs.

It may be observed that all payor systems could protect some carriers from legitimate and effective competition. Arguments for such protection are not persuasive because consumers are unlikely to suffer from the disappearance of the less efficient carriers. In order to survive in the marketplace, many Blue Cross and Blue Shield Plans and some other carriers have successfully negotiated provider prices to cover the costs of care for subscribers. These amounts may not be as much as hospitals would like, nor as little as payors would prefer, but they represent prudent business practices and reasonable compromises. We have committed our financial and management resources to make this payment strategy work. Those carriers which are either uninterested in or unsuccessful in negotiating prices must find something else of value to offer accounts and consumers or fail in the market. The Blue Cross and Blue Shield Plans are confident that they can develop products that are competitive even in areas where their market share is low.

ERISA. We have concerns about some costly and perhaps unintended consequences of the Employee Retirement Income Security Act of 1974. That law preempted state authority to regulate employee benefit plans. Employers wno do not buy insurance, that is, who self-insure their benefit plans, are not subject to state laws that require specific benefits. Such laws, which vary widely and add to premium costs, make it more difficult for us to offer consistent cost-containing benefit plans to our accounts. We urge the Committee to explore this issue further. We would be pleased to offer recommendations on how the law might be amended to allow both us and commercial insurers to offer more cost effective benefit packages while retaining of states regulatory authority over insurance.

SUMMARY

In conclusion, we feel that the Blue Cross and Blue Shield organization has made considerable strides in controlling health care costs through a variety of programs. While there is more that needs to be done, we are committed to continuing effective existing cost containment programs and experimenting with new ones. Such initiative is essential in our market.

We believe that there are important roles for both competition and reasonable regulation in the health care system. Unlike the situation a decade ago, market competition is creating intense pressures to control health costs. Evidence of these market forces includes the development of alternative delivery systems, growing provider competition, and hospital reorganization, diversification and consolidation. These developments can be easily overlooked because market forces in the health care system have worked slowly as compared to other economic systems. Public and private policies have tended to discourage rapid market change because the potential for negative effects on access to quality care is so serious. Pure market forces work poorly when they create disincentives to treat the poor and the very ill and when they penalize providers who do treat them, even to the extent of eliminating these providers from the market. Where market forces work poorly, there is an important role for government policy.

In both the public and private sectors, the urgent need for cost control must still be balanced against social concerns for access and quality health care. We are committed to this course and believe that these objectives are central to this Congress's work as well.

Mr. Chairman and Members of the Committee. Thank you for this opportunity to share our experience and concerns with you. The Blue Cross and Blue Shield Association offers its assistance in developing health care cost control policies, and I welcome the opportunity to respond to any questions you may have.

Question #1:

Are there any barriers for the insurance market to reduce costs in health care? Specifically, are there barriers to insurance companies negotiating prices with providers?

Answer:

There are some public policy barriers in the form of legislation and court decisions that limit private cost control efforts. For example, one way Blue Cross and Blue Shield Plans, HMOs, preferred provider organizations, self insured employer benefit plans and some commercial insurers have controlled cost is through the contractual purchase of health care services from providers. Rather than accepting provider-determined charges, many Plans negotiate directly with providers to arrive at payment levels that reflect both the costs of caring for their subscribers and the benefits resulting from their business practices (e.g., prompt payment, non-group coverage). These contracts address not only price but such additional cost containment issues as utilization restraints.

One barrier to cost effective purchasing from providers is "all-payers" legislation. A few states require all payers to pay for hospital services according to state regulated rates, and there has been some discussion about extending the federal prospective payment system to all payers. Although government intervention in the market for health services may be justified under certain circumstances, in other circumstances it inhibits private efforts to control cost through price negotiation and through programs designed to meet specific community cost problems.

Since research findings on state hospital rate regulation are mixed, there is little basis for believing that the approach would be successful in imposed nationwide. Rather, an all-payer system would protect both inefficient insurers and providers from market competition and restrict the cost containment opportunities for those who are efficient. We believe that most Blue Cross and Blue Shield Plans will be able to control costs effectively and competitively through aggressive price negotiation and other cost containment programs.

A different type of constraint on cost control through price negotiation has arisen from judicial action. The 1945 McCarren-Fergeson Act provides an exemption from the antitrust laws for "the business of insurance" that is regulated by state law. The 1979 decision in the Royal Drug [1] case held that insurors' contracts with health care providers are not part of the business of insurance and are, therefore, subject to scrutiny under the antitrust laws. Subsequent to that decision, providers have filed a number of antitrust actions challenging Blue Cross and Blue Shield Plan contracts with providers. Although to date these contracts have been uniformly upheld as lawful, the cases are very costly to defend since without an antitrust exemption, each must go to a full triel on the merits. We support the concept of litigation of important issues appropriate for judicial resolution, but we consider continual retesting of the legality of Plan contracts to purchase health care services a costly waste of time and effort. Such nuisance suits engendered by the Royal Drug decision offset some of the cost savings that are the purpose of these contracts, and also inhibit the negotiation process.

State mandated benefit laws also create problems for Plans in designing cost-effective benefit packages. Coverage is sometimes required for services that subscribers do not want and that may not be medically sound, necessary or within the purview of health insurance. Rigid benefit requirements also limit the ability of Plans and their accounts to match benefit design to other cost containment strategies. Furthermore, wide

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1. Group Life and Health Insurance Company v. Rogal Drug Company, 440 U.S. 205 (1979).

variation in state laws increases administrative costs and complicates rational benefit design for multi-state employers. The Employee Retirement Income Security Act of 1974 (ERISA), which preempts state authority to regulate employee benefit plans, but not insurance regulation, could be amended to permit insurers and their customers to design more cost effective benefit plans without removing the vast majority of state regulatory authority over the insurance industry.

Question #2:

Mr. Morris, several of the other witnesses today have discussed the need to better educate the public on health care costs. I heard no mention at all of this in your testimony. Does the absence of any regard for this tactic indicate a belief on your part that it is not a worthwhile avenue to pursue?

Answer:

For reasons of brevity, I singled out only six of our many cost control programs for discussion in my testimony. Health care cost education for consumers, employers and providers is both a discrete Blue Cross and Blue Shield program area and an integral aspect of other cost containment programs such as utilization control and benefit design.

Blue Cross and Blue Shield Plans are subject to a Blue Cross and Blue Shield Association Cost Containment Membership Standard that covers a wide variety of programs including health education. Our recent survey of Plan health education activities found that virtually 100 percent of the Plans provide information or literature about health care cost containment issues. Plan cost containment programs, and the proper and judicious use of health care services and insurance coverage. As an example, Plans encourage use of appropriate outpatient surgery and testing and discourage unnecessary hospitalization and benefit utilization. In addition, corporate decision-makers are educated about employee health care cost containment strategies. Newspaper, radio, and television advertising is then used to reach the general public.

Plan health care cost education programs also focus on health care professionals in order to encourage cost effective practice patterns. For instance, some Plans develop individual physician profiles of number of admissions, length-of-stay, average total bill for each admission, and other data to distinguish individual physician practice patterns. Physicians learn how they generate health care costs and how their practice patterns differ from those of their peers. In many instances physicians have changed costly practice patterns once they were provided with this information. During 1981, one Plan estimates that this program saved $1.5 million.

In sum, Blue Cross and Blue Shield Plans do consider health care cost education to be an important component of their cost containment programs.

Question #3:

From your position as a major carrier in the federal employee health benefit — a case study in consumer choice — do you think significant savings are achieved through formatting health benefit programs in this manner?

Answer:

No. Multiple-choice programs which feature many different levels of benefits, different carriers, and different prices have two major consequences:

(1) The more experienced and sophisticated the employee-consumers become, the more they choose on the basis of their own projected needs — i.e., the younger, healthier employees anticipate less need for health care, want to spend as little as

possible for insurance protection, and hence select the less expensive plans. By the same token, older, less healthy employees choose in the other direction. Over time, the employee "risk pool" becomes highly fragmented, and the broader coverage, more expensive plans become ever more expensive — due to the higher utilization experience of their members — thus driving out members who do not feel they're "getting their money's worth" — and the spiral goes on. Fundamentally, the principle of group insurance, of spreading risks across a broad cross-section of people, is lost. At the end of the spiral, the people who most need insurance protection are least able to obtain it. The coverage they want becomes prohibitively expensive and/or the carrier either drops out of the program or goes into bankruptcy.

(2) The carriers who participate in these programs, once they fully understand the dynamics of adverse selection described above, must conclude that the simplest "cost containment" actions they can take are to attract healthier customers. Tougher actions, such as intense utilization review, price-negotiation with providers, low administrative costs, etc., are only necessary for those carriers that have proportionately more of the bad risks than the carriers with whom they compete. In other words, the adverse selection dynamic promotes a competition among carriers to "get the best risks", rather than to seriously and universally address health care cost containment actions that can result in significant savings.

In this kind of program people are encouraged to "game the system", i.e., to move into broad coverage plans when they need them, and back out as soon as they don't. People who actively seek to minimize their personal costs can often do so in this kind of system, but there is no evidence that the multiple choice method yields system-wide savings, or even savings to the government. There is evidence that the employees who need and choose the most protection will pay more for it than they would in a less fragmented group environment.

As a footnote, I should note the outcome I described is not limited to the Federal Employee Health Benefits Program. In a study prepared by Arthur D. Little, Inc. in May 1983, under contract with the Department of Health and Human Services, it is pointed out that in response to the question, "Do Competitive Benefit Plans Cut Costs?" that "The evidence from the plans studied does not give a clear signal that competitive benefit plans will cut the total cost of health care provided by the employer, or the total cost of health care to society."

Senator **Hawkins**. Thank you, Mr. Morris.

Mr. Owen, the Florida Hospital Association estimates that medicare only reimburses 67.7 percent of the charges that a patient generates. Since over one-half of all the patient days are medicare reimbursed in Florida as compared to the 39 percent nationwide, this results in a significant "sick tax" which is added to the minority of patients who pay the full charges.

If Congress continues to focus its legislative initiatives only on reducing medicare and medicaid funds, won't it just increase pressure on the States to institute rate-setting legislation to prevent this cost shifting?

Mr. **Owen**. What we are hoping is that as you look at a DRG prospective payment system, we are going to get some change in behavior in the way that hospitals take care of patients in the hospitals in Florida and other parts of the country, because we have seen it happen in some areas where it has been in effect.

If there is a change in behavior and if the hospital and the medical staff are successful in reducing the resources that go into each case and the price does not drop but stays where it is, then the hospital will fund closer to what its expenses are, what it says its expenses are, and what its revenue will be, so that that should help.

If that does not occur, if the medicare funds dry up, then there would have to be some revenue shifted from somewhere, because there is no such thing as free care. We have to pay for the food and we have to pay for the drugs, and we have to pay the salaries of the staff who take care of patients. So free care is really nonexistent.

I don't see that we are in such a position at this point in time, because to date medicare has not actually cut back on the amount of money that it pays hospitals; what it has done is reduce the increase in the expenditure level.

Senator **Hawkins**. Mr. Morris, in Florida, Blue Cross/Blue Shield is the largest provider of health care. Florida Blue Cross/Blue Shield and its 232 contracting hospitals within the State have developed their own voluntary cost containment program using such mechanisms as prospective charge payment, hospital charge unit, audit, usual, customary and reasonable physicians' reimbursement, and hospital utilization review.

How successful are these voluntary efforts?

Mr. **Morris**. Well, Senator, I think they underscore the point that health care is, by definition, delivered on a community basis, and communities do vary quite considerably with respect to their capacity, excess capacity, undercapacity, teaching loads, charity loads, such things as have been referred to earlier this morning.

The Florida program illustrates to me the desirability of having various forces within that State who understand the needs and understand the opportunities and understand perhaps the future that will be imposed upon that system identify what can and should be done in that environment. We encourage that kind of thing very much.

Now, there have been instances—and Massachusetts has been cited as one this morning—in which that kind of discussion has led to a decision that all parties involved would be well served by an all-payer system. That sort of conclusion emerges from that kind of discussion. Again, I think it is most desirable that the communities sit down and decide what they want, what they can afford, what their priorities are, and proceed accordingly.

Senator HAWKINS. Do you think there are any certain governmental programs or policies which encourage the costs of health care?

Mr. MORRIS. Well, Senator, I think we need to define the role of Government. Government has several roles in this arena. Government is a very large purchaser of care. Government is a very large provider of care through Federal hospital systems. And Government is, of course, a regulator.

Government has just taken very considerable steps, certainly the largest steps since 1966, in changing the payment mechanism for medicare. Generally, we have supported that. I share Mr. Owen's view that it changes incentives, and that is a very constructive thing to have done. How it plays out will have to be seen over the next few years. It is going to be complex to administer. We are going to have to learn as intermediaries how to handle it. The hospitals are going to have to learn as providers of care how to handle it.

We will get optimum results if the management of the hospital integrates the DRG into its thinking and behaves accordingly. I share Mr. Owen's views on that.

As a regulator, it seems to me Government's role ought to be intervention when the market is not solving its own problems. Medicare itself was a significant example of that. It became very, very difficult, with an increasing number of aged people and explosive technology, for the private market to absorb the much higher experience. Government then stepped in to provide a different means of financing that care.

But again, I would see Government as intervening when these objectives are not achieved through private means or, preferably, on a State basis as a participant in the kinds of discussions that we were talking about a couple of minutes ago.

Senator HAWKINS. I read in the paper recently that Blue Cross/Blue Shield had managed to cut their hospital admissions by 9.5 percent during the last decade, at a time when hospital admissions for the general population increased by 11 percent. How did you manage to reduce your hospital admissions?

Mr. MORRIS. Well, it is a result of a number of things, Senator. It is not any one thing. Perhaps the most important thing is to provide alternatives to inpatient care so that you are not providing incentives for people to go into the hospital when it really isn't necessary.

Senator HAWKINS. Such as paying for doctors' office visits?

Mr. MORRIS. Not only doctors' visits but outpatient hospital services, surgicenters, medical centers, free-standing emergency centers, alternatives to inpatient care.

A different and somewhat tighter view of medical necessity is a part of it. We have worked very hard over a period of years with a number of medical organizations to define what kinds of care are appropriate and what kinds are not.

The existence of alternatives to the conventional system—HMO's, PPO's—are a factor. Cost sharing, which we now write in some volume, but which we seldom used to write, may be another factor.

Senator HAWKINS. Do you have any estimates on the cost savings attributable to these reduced hospital admissions?

Mr. MORRIS. Well, the days per thousand, which is probably the single best index of cost—I cannot give you dollars—have dropped in our system from about 920 days per thousand in 1970, to 699 in 1982.

Senator HAWKINS. Nine hundred and twenty days?

Mr. MORRIS. About 920—the figure is close; it may not be precise—in the year 1970, to 699 in 1982. The product has changed; the cost per unit has changed; the intensity has changed. It is very hard to quantify in dollar terms. But as a standard measurement, days per thousand are of that magnitude.

Senator HAWKINS. You cannot give a dollar savings?

Mr. MORRIS. I don't think I could at this point.

Mr. OWEN. You could almost figure it, Senator, if you looked at the average cost of $304 per day and used that as a multiplier—I think the price has changed. That is what he was referring to. But in today's actual dollars, you could determine the amount.

Senator HAWKINS. Mr. Owen, could you explain why you don't support existing health planning laws?

Mr. OWEN. The AHA may change its position. Our position has been up to this point that we oppose certificates of need—that planning should be left to the States, from a Federal Government standpoint, and take place at the local level as close to the hospital as possible.

The position that we have had is that we are opposed to planning per se, because market forces should be the determinants. We are beginning to rethink that view.

I am on my way to Chicago this afternoon. Our board of trustees is meeting, and I plan to discuss the AHA's planning position with the board members. I suspect that we may move from our position of outright opposition to planning and adopt one that favors a planning program with flexibility using State and local bodies to do the planning.

Senator HAWKINS. Thank you so much. We will excuse you at this time.

The hearings on health care costs and possible solutions have benefited greatly from your participation.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

[The material referred to follows:]

FREESTANDING AMBULATORY SURGICAL ASSOCIATION

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June 8, 1983

Hon. Orrin G. Hatch
Chairman
Senate Labor & Human Resources Committee
SD-428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

The Freestanding Ambulatory Surgical Association (FASA) appreciates the opportunity to submit for the record its views on the important subject of controlling health care costs.

FASA represents freestanding ambulatory surgical centers -- facilities designed, equipped, staffed and operated to accommodate the needs of patients undergoing surgical procedures that are too intricate to be safely performed in the surgeon's office, but that do not require overnight hospitalization. These "free-standing" centers are not connected to a hospital -- either physically or organizationally.

The development of freestanding facilities for the performance of certain less complex surgical procedures on an ambulatory, or outpatient, basis is a relatively recent but significant response to the rapidly rising costs of health care. Since the opening just 13 years ago of the first freestanding "surgicenter" in Phoenix, Arizona, over 200 such surgical centers are now providing cost-efficient, quality surgical care to hundreds of thousands of patients each year. Attached is a recent article describing the benefits in terms of time and money of freestanding ambulatory surgery.

THE SOCIETY FOR THE ADVANCEMENT OF FREE STANDING AMBULATORY SURGICAL CARE
1040 EAST McDOWELL • PHOENIX, ARIZONA 85006 • (602)258-1528

BENEFITS

In the 13 years of their existence, freestanding ambulatory surgical centers have been among the leading proponents and practitioners of innovative, cost-effective health care. Freestanding ambulatory surgical centers reduce health care costs by eliminating unnecessary overnight stays and other ancillary costs. Ambulatory "surgicenters" have been pioneers in many of the cost control methodologies that are currently being recommended for consideration by this Committee. For example, ambulatory surgical centers have been operating from their inception under a prospective payment methodology. In our experience, prospective payment works. It is effective in containing costs. We have also found that patients prefer knowing costs ahead of time. We would urge that prospective reimbursement be expanded to cover all payers.

Not only is surgery performed in an ambulatory setting cost efficient, it is also safe. No operation is completely without risk, but ambulatory surgery has an impressive safety record; the incidence of complications requiring transfer to inpatient hospital facilities is fewer than 1 per 1,000. Having surgery in a freestanding setting also lowers the risk of contracting infection.

Close to 700 surgical procedures are currently approved by health insurers for performance in an ambulatory surgical setting. Physicians in such specialties as gynecology and obstetrics, urology, opthamology, dental surgery, orthopedics, ear, nose and throat surgery, plastic surgery, and pediatrics, among others, are today performing surgery by choice in freestanding ambulatory settings.

The entrance of freestanding ambulatory surgical centers into the marketplace has had a demonstrable competitive effect on health care delivery and health care costs in the communities they serve. In response to the presence of freestanding surgical centers, existing hospitals, which had previously not provided outpatient surgery, have opened outpatient facilities. Hospitals which were already operating outpatient surgical facilities have reduced their charges to remain competitive with the new freestanding surgical centers.

Recognizing the great cost savings to be achieved, many health insurers have provided reimbursement incentives for the use of ambulatory surgical facilities, providing a higher level of reimbursement for ambulatory surgery (often at 100%) than for the use of traditional in-patient treatment.

Ambulatory surgical facilities provide a highly desirable method to achieve demonstrably high quality surgical care at a significant cost savings -- often as much as 30% to 60% less than the inpatient alternative. By eliminating the need for hospital stays, freestanding surgical centers also eliminate one of the greatest costs involved in surgical treatment. Recognizing the significant cost savings to be achieved, the Congress, in 1980, approved reimbursement for certain surgical procedures performed in freestanding ambulatory surgical centers under the Medicare program.

BARRIERS

Despite the demonstrated ability of freestanding surgical centers to provide quality surgical care on a cost-effective basis, and despite the rapid growth of the "surgicenter" concept throughout many parts of the country, ambulatory surgical centers face formidable barriers in attempting to provide quality surgical care at a competitive price.

As previously mentioned, surgical procedures performed in an ambulatory setting were approved for reimbursement under Medicare in December 1980. The Health Care Financing Administration (HCFA) issued a request for information in formulating proposed regulations on May 22, 1981. Proposed regulations to implement this new law were issued on March 22, 1982. FASA submitted detailed comments to HCFA in response to these notices and requests. Final regulations were issued on August 5, 1982, 2-1/2 years after Congress acted. As of today, not one ambulatory surgical facility has received the first check from Medicare. Considering the cost efficiencies to be achieved with ambulatory surgery, the long delay in implementing this new program represents considerable lost savings to the Medicare program. Similar delays in implementing other health cost innovations result in even greater lost savings to the government. FASA urges renewed efforts to expedite the adoption and actual operation of new initiatives to improve the quality of health care at lower costs.

State and local interpretation of Federal health planning laws have often served as a barrier to entry by freestanding ambulatory surgical centers and other innovative health care providers into the local health care marketplace. Rather than serving their true role in encouraging efficient use of health care resources by improving patterns of utilization, some state and local health planning agencies serve as de facto defenders of the status quo. Some of these agencies have unnecessarily restricted issuance of certificates of need to freestanding ambulatory surgical centers, thus keeping surgicenters out of the health market. In such localities, there are few, if any, competitive incentives to control health costs.

FASA appreciates this opportunity to bring to your attention the role that ambulatory surgical centers are playing in providing quality health care on a cost-efficient basis. In general, we applaud the efforts of this Administration and this Congress in encouraging competition in the health care marketplace and we urge your continued leadership in encouraging greater control of national health care costs.

Sincerely yours,
Bernard A. Kershner
Bernard A. Kershner
Chairman, Government Relations
Committee

Senator **Hawkins**. The committee stands in recess.

[Whereupon, at 12:47 p.m., the committee recessed, to reconvene at the call of the Chair.]

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